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a professional journal on services for children and on child life

(*formerly* THE CHILD)

Back of Dr. Nicholson Eastman's thinking about the problems of maternity care are three decades of professional work in obstetrics, both as teacher and practitioner. He served as associate and professor in obstetrics and gynecology in Peiping Union Medical College, China, in the 20's and 30's. Since becoming obstetrician-in-chief at Johns Hopkins Hospital in 1935, he has authored a book, Expectant Motherhood, in 1940, and coauthored (with L. Zabriskie) Nurses Handbook of Obstetrics, in 1943.

Child Study Association of America, which Dr. Gunnar Dybwad has directed since 1952, has been outstandingly successful in disseminating information on child development and in raising the professional level of parent group education. Dr. Dybwad served from 1942 to 1951 as State Child Welfare Director in Michigan. Currently he is chairman of the Committee on Child Welfare of the National Council of Churches of Christ, and of the Parent Education Section of the National Council on Family Relations.

Dr. Fritz Redl, one of this country's foremost authorities on child group psychology, left his professorship in social work at Wayne University, Detroit, Mich., to undertake his present study. Austrian-born, Dr. Redl received his doctor of philosophy degree from the University of Vienna and his training in child analysis from the Vienna Psychoanalytic Institute. His books, Children Who Hate and Controls from Within, have received wide acclaim.

Harriett Bartlett's interest in defining the function of professional social work has been ably demonstrated in her continuing participation in study projects of the American Association of Medical Social Workers and the Council on Social Work Education. Before taking her present post as professor and director at Simmons College, Boston, she was associated for 20 years with the Massachusetts General Hospital.

The Pennsylvania Citizens Association, through its alert magazine CURRENTS, led us to the story, felicitously told by Helen C. Hubbell, of how child welfare services came to Sullivan County, Pa. Miss Hubbell's 30 years in child welfare have included experience in voluntary and private agencies in New York, Massachusetts, and Pennsylvania.

When Betty Hutchinson went to Panama as a technical consultant, she could walk right into her job with no language difficulties because her first 13 years of life, spent in South America, had given her an excellent knowledge of Spanish. Her professional career includes 3 years as a hospital social worker, under the Red Cross, in India, Korea, and the Philippines.

frontispiece

"From looking in their faces comes again pride in being human, and a sense of infinite possibility in mankind."
Ernestine Evans, Author.

These Detroit, Mich., school children were photographed by Ralph Showalter for the United Automobile Workers–CIO.

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CHILDREN'S BUREAU
Martha M. Eliot, M. D., *Chief*

a foreword and a pledge

TO OUR READERS

THIS NEW PROFESSIONAL JOURNAL on services for children and on child life arrives in time to herald the 42d birthday of the Children's Bureau which occurs on April 9, 1954. A publication of the Bureau, but not its captive, CHILDREN will, nevertheless, reflect the Bureau's objectives.

Throughout its history, one objective has towered above all others, and this one, we frankly admit from the beginning, will color and shape the contents of CHILDREN: the objective of providing ***a basis for action in behalf of children.***

• • •

Two women and two committees of the Congress can take credit for launching the Children's Bureau in this direction more than four decades ago.

The two women were Lillian Wald, founder of the Henry Street Settlement, in lower New York City, and Florence Kelley of the National Consumers' League. Their story deserves to be told again.

On a day in 1906, while they were having their morning coffee at the Settlement, two letters came in the mail. "Why is it," one of these letters asked, "so many children die like flies in the summer time? Is there something I can do to help matters?" The other letter was from a mother whose husband had died. She was troubled because, now that she had to go out to work to support her children, she would have to put them in an institution.

"There must be thousands of mothers all over the United States in just the same situation," observed Miss Wald. "I wish there were some agency that would tell us what could be done about these problems."

Miss Wald and Mrs. Kelley turned to the morning newspaper. The Secretary of Agriculture, the paper reported, was going South that day to find out how much damage the boll weevil was doing to crops.

That gave Miss Wald an idea.

"If the Government can have a department to take such an interest in what is happening to the Nation's cotton crop, why can't it have a bureau to look after the Nation's crop of children?" she asked.

Miss Wald passed the idea to a friend who wired it to President Theodore Roosevelt. "Bully!" the President wired back, "Come down and talk to me about it."

Six years later the idea had matured into the law creating a Children's Bureau and charging it to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people."

That this investigating and reporting were to be for a purpose was made amply clear by the two Committees of the Congress which recommended the creation of the Bureau.

Information is needed, said these Committees "to enable them (the States) ***to deal*** more intelligently and more systematically and uniformly with . . . the betterment of the conditions of children," and "in order that they (the various charitable and humane organizations interested in the welfare of children) ***may do their work*** more wisely and effectively."

• • •

These directives clearly marked a difference between the Children's Bureau and such research agencies of Government as the Bureau of the Census, for example. The latter has always been and still is a fact-gathering organization; it carries no responsibility for the application of the facts which it gathers and reports. The Children's Bureau, on the other hand, was charged with contributing to the "betterment of the condition of children," according to the Senate Committee, and its investigations and reporting were to that end. Since fact finding was to lead to action, it was not enough that the Bureau find out merely ***what*** was happening to children. It must study, too, ***why*** it was happening, and ***how*** "abuses" could be "checked." The history of the Bureau's investigations and reports is alive with the ***what***, the ***why***, and the ***how***.

With a stream of facts flowing out to citizens on how good jobs are being done, and how they might be done, it was a logical next step for citizens, eager for action, to look to the Bureau for help in doing good jobs.

Responding to this demand, from its earliest days and throughout its life, the Bureau has, with the help of outstanding authorities, developed standards of good care in many fields.

• • •

But knowing what is good to be done is not always enough. There must be the wherewithal, as well as the know-how, to bring good practices to life.

So the third logical next step was taken by the Congress when it made the Children's Bureau responsible for administering various laws to help States financially in improving the conditions of children.

The first of these laws was passed in 1921 when the Congress authorized $1,200,000 to be given each year to the States to help them improve their health services for infants and for mothers during childbearing. The Children's Bureau was made administrator of these history-making grants-in-aid.

The Federal Maternity and Infancy Act had a relatively short life. It expired in 1929, but it laid the ground for title V of the Social Security Act, passed in 1935 and in operation continuously since, authorizing funds to be given annually to the States to extend and improve health and welfare services for children.

To assemble facts needed to keep the country informed about matters adversely affecting the well-being of children; to determine what kinds of

health and welfare measures and methods are most effective in aiding children and their parents; to work with citizens and agencies in improving the conditions of childhood; and to administer the financial aid that the Federal Government gives to States for this purpose: these, then, are the interlocking, intermeshing purposes of the Children's Bureau. It is good practice for financial aid to be based on knowledge of the facts and standards of service. Knowledge of the facts and good standards that fail of application are sterile.

Enormous changes have taken place during the Bureau's 42 years in the character of children's problems on which action is needed. The tally of achievements is too long to list here. They are accomplishments of the Nation in which this Bureau has played a part, but only a part.

• • •

Alfred Lord Tennyson once said:

Yet all experience is an arch wherethro'
Gleams that untravell'd world whose margin fades
For ever and for ever when I move.

The margins of the untraveled world of the good life for all children seem not to shrink, as progress is made in defeating one enemy of childhood after another, but to grow with discovery and experience. A purpose of CHILDREN will be to bring those margins nearer by reducing, if it can, the time lag between discovery and application.

A chief method of science, Harry A. Overstreet observes in his book, The Mature Mind, has been that of ***dividing to conquer.*** "By this method," he writes, science "has put at our disposal a well-nigh incredible body of facts regarding everything from the behavior of the atom to the behavior of the human mind confronted by a problem."

This proliferation of approaches both to problems and to solutions shows up dramatically in the history of child care. One development of greatest significance in the first half of this century has been the growth of specialization in professional services for children. No State or local health department offered in 1912 the range of services that the average one today provides. Child welfare divisions in State departments of welfare were nonexistent.

"Now, apparently," Professor Overstreet predicts, "science is ready for a new method: that of ***uniting to conquer.*** What has been divided and subdivided for purposes of research is now being reassembled for purposes of interpretation and of application to human affairs."

• • •

In keeping with this new method, CHILDREN will address itself "across the board" to all professions concerned with the well-being of children. It will direct itself to practitioners, executives in programs, teachers in professions, and research workers, whatever their specialty in child care is. By intentionally favoring material of interest or concern to more than one profession, CHILDREN hopes not merely to add to interprofessional understanding and teamwork but also to multiply the effectiveness with which each profession deals with its own problems.

CHILDREN will offer its readers a balanced fare of technical articles on health, welfare, and child development. It will relate what needs doing, and why; who's doing what, and how. It will include data, discussion, and debate, on the physical, social, emotional, and cultural aspects of child growth and development; on standards of child care and professional training; on developments in professional techniques, personnel, and in programs serving children and their parents.

CHILDREN is designed to be neither house-organ nor oracle of the Children's Bureau. It will be a medium of exchange of ideas between and among professional people. As a journal of exchange, principal contributors to CHILDREN will be persons outside the Children's Bureau. CHILDREN will welcome, particularly, contributions from persons of professional competence who can give another side of, or a new slant on, a subject which it has already presented.

While the contents of CHILDREN will, of course, be in harmony with administrative policies of the Department of Health, Education, and Welfare, the point of view of no article by an author not in the Children's Bureau is necessarily that of the Children's Bureau. There will be generous space for readers' comments. Indeed, readers are invited and encouraged to participate in discussion of all matters dealt with in the journal.

In addition to publishing substantial articles of professional significance, the journal will include items of news, and notices of books, films, and other materials useful to professional workers.

In its small way, CHILDREN will carry forward a service that the Children's Bureau has attempted, throughout its lifetime, to provide to professional workers in many ways: through person to person contact, through advisory boards and conferences, and through print. That is, to be a catalyst in speeding up the processes of research and of practice out of which will some day come that "state of complete physical, mental, and social well-being" we crave for all children from conception to maturity.

The usefulness of this journal will depend upon how well it serves the needs of its readers. We will appreciate greatly leads from them to new, unique, or otherwise significant developments in programs and research for children. We count on them greatly to give us the kind of friendly criticism on which we can grow in effectiveness.

Martha M. Eliot

Chief
Children's Bureau

a distinguished obstetrician asks how more mothers can get better care in child-bearing, and offers, for discussion, one proposal

MATERNITY CARE LOOKS TO THE FUTURE

NICHOLSON J. EASTMAN, M. D.
Professor of Obstetrics, Johns Hopkins University School of Medicine

THE RECORD OF MATERNITY CARE during the past few decades has been one to evoke gratification and pride. But in this rapidly changing world, maternity care must anticipate the future if it is to continue to serve the best interests of womanhood.

The greatest problem which maternity care will face in the next decade is personnel. Even today there is cogent evidence pointing to a shortage of physicians. In the last 30 years the output of physicians has merely kept pace with the growth in population. Meantime, the demands for medical services have soared. The expansion of public health programs, of industrial medicine, of mental hospitals and of research, plus the pressure of military requirements, have reduced the number of actual practicing doctors, in relation to population, to a figure lower than it was either in 1940 or 1949. Even a cursory survey of our 7,000 hospitals will show that only a small minority can secure an adequate house staff; many have none whatsoever. According to a recent report of the Council on Medical Education and Hospitals of the American Medical Association, there are about 3,000 more approved internships in the United States today than there are interns. In a certain large municipal hospital, a fourth of the babies are born without benefit of medical attendance, simply because three lone interns cannot handle 4,000 deliveries a year.

The forecast for the future is still more worrisome. On the basis of an expected population of some 171,000,000 in 1960, the Commission on the Health Needs of the Nation predicted that 30,000 more physicians than the anticipated supply in 1960 will be required to give reasonably comprehensive care to the entire civilian population and to meet the pressing needs of the public health services, industrial medicine, mental and tuberculosis hospitals, faculties of medical and public health schools, and the armed forces.

In view of the dearth of physicians predicted for 1960, those interested in maternity care will note with concern that in the late 1960's a sharp rise in birth rate is probable. In the mid-forties any overworked obstetrician could have warned his Commissioner of Public Schools to expect a huge increase in first grade pupils around 1953; and exactly this has happened. By the late 1960's these same first graders will be reaching marriageable age and it can be forecast with reasonable certainty that the marriage bureaus of that decade will be just as overcrowded as are the school houses of today. This means of course more babies and more maternity work. Some idea of the extent of this increase may be visualized from the following figures; the number of young persons who will attain the age of 20 in the late 1960's will exceed by more than one-third those who are reaching that age during the present decade; the number of young persons who will reach their sixteenth birthday during the single year of 1963, it so happens, will exceed by more than two-thirds those who attained that age during the year of 1953.

But these are not the only factors to be considered in evaluating the future adequacy of maternity personnel. Of the number of doctors who will be avail-

able, what percentage will elect to practice obstetrics? Will the proportion be more or less than today, or perhaps about the same? Although this question cannot be answered with certainty, the evidence suggests that the percentage will not be more and may be less. Those of us who have given our lives to obstetrics and who list it high on the roster of essential medical services will admit with reluctance that it is not a popular specialty. But this is the truth. Many general practitioners will tell you that they continue obstetrical work solely because it engenders good family relationships and so contributes to the development of their practice in other fields. A surprising number of obstetric and gynecologic specialists, when they get to be about fifty, decide to "graduate" (so they say) into straight gynecology because of the long, irregular and unpredictable hours which obstetrics imposes. As the ranks in other specialties start to thin, can obstetrics still attract its present quota of practitioners? It is conceivable that this question may be answered in the negative.

Although the outlook for adequate obstetric personnel over the next decade is therefore discouraging, there is no reason for outright pessimism provided immediate steps are taken to meet the threat. Even if these dire forebodings do come to pass, it will not be the first time that obstetrics has faced a shortage of physicians. In World War II, as their younger colleagues went into uniform, a large number of obstetricians confronted the onus of delivering 700 and more babies a year. This means, on the average, two deliveries a day in addition to miscarriages. It means, on the average, one patient in labor all the time, day and night, 365 days of the year. When account is taken also of the irregular spacing of these deliveries plus the huge amount of prenatal and postnatal care entailed, the magnitude of the assignment would appear more than any one person could possibly manage. Nevertheless, it was managed and, by and large, managed safely.

How was it done? To the credit of these obstetricians let it not be forgotten that the most important factor was ceaseless work on their part to the point of physical collapse. But, another factor also proved indispensable and helped greatly to save the day: to wit, the assistance rendered by nurses trained to a certain extent in clinical obstetrics. After a suitable period of instruction these nurses were prepared to perform, if need be, the following functions: in prenatal care, history taking, blood pressure determinations, venipunctures, abdominal palpation, fetal heart observations and attention to the more common complaints such as nausea, heartburn, constipation and excessive weight gain; in labor, they were trained to carry out, in addition to the procedures just mentioned, rectal examinations, emotional support of the patient and, indeed, pretty much the entire conduct of labor except actual delivery. The latter they undertook only as an emergency. If, at any time, the slighest abnormality developed, the obstetrician was notified. Actual analysis of the case records of obstetricians who followed this pattern of maternity care, reveals that at the first visit, the patient was always examined and interviewed by the physician; on subsequent visits she was examined by the obstetrician once in every three visits perhaps but brief interviews might be more frequent. The number of examinations carried out by the physician

NATIONWIDE SHORTAGES of well-trained workers are reported in many professions serving mothers and children. More people are making more demands for such personal services. Techniques of care constantly become more complex. Increasing use of professional health and welfare personnel in administration, teaching, research, and Government adds to the pressure on supply.

What can be done to meet both present and prospective requirements for such workers? This is a question that gives pause to the thoughtful in all professions.

Here is one expression of concern and one proposal in the field of maternity care. It is presented without official endorsement by this publication or by the Children's Bureau, but in the conviction that any thoughtfully advanced method of meeting this need merits discussion.

As a forum for the exchange of professional opinion, CHILDREN invites its readers to share with each other, through the pages of this journal, their findings and their feelings about this and alternative proposals for resolving so important a national problem.

in the course of labor and the time he spent at the bedside varied with the exigencies of the moment.

This, then, is a program of maternity management in which the obstetrician relies heavily for the minutiae of care on specially trained maternity nurses. They act, as it were, as "obstetric assistants" and constitute an important part of a maternity team. It is an arrangement which has saved untold hours for obstetricians and which, in actual practice, has worked, and worked safely.

Questions will of course be raised about the dependability of these nurses' observations, both in prenatal care and in labor; but anyone with much experience in obstetrics will probably agree that the errors and oversights of such a nurse would be fewer in the long run than those of a hurried, harassed and exhausted obstetrician. In all likelihood they would be just as reliable as those of an intern, probably more so; but there will be no question of competition here with interns because, if the prognostications set forth in the first paragraphs of this article are correct, a huge number of hospitals will have no house staff.

If the utilization of skilled maternity nurses with advanced clinical training has proved helpful when obstetricians in private practice have been faced with a shortage of medical personnel, the same general principle would seem applicable to other areas of maternity care, for instance, to vast sections of the South where about one-half of the nonwhite births occur in the absence of either a physician or a nurse. But, at this juncture, let us be absolutely certain that this "general principle" is clearly understood. It entails the use of highly trained maternity nurses who ***work under the direction and control of an obstetrician.*** Any thought of resurrecting the independently operating midwife is out of the question. That is why the terms "Advanced Maternity Nurse" or "Obstetric Assistant," long and clumsy as they are, may be preferable to "Nurse-midwife." But, no matter what appellation is decided upon, the prerequisites to success of any such plan are (1) that a physician examine and screen all patients at the onset of prenatal care, and, through the nurse, assume indirect responsibility for such normal gravidae as are turned over to her; and (2) that the obstetrician, by a pre-arranged and well organized plan, be available for consultation throughout pregnancy, labor, and the puerperium. As for the workability of this plan in underdeveloped rural areas, a very similar program proved highly successful on the Eastern Shore of Maryland during World War II and, as everyone knows, this general arrangement constitutes the pattern of the Frontier Nursing Service whose record in certain isolated areas of Kentucky is enviable.

In both the Maryland and Kentucky programs, home delivery was the rule except in complicated cases. The concept of maternity care which is here envisaged for underdeveloped areas postulates hospital delivery by these specially trained nurses. That, at least, should be the goal because home delivery, quite apart from other drawbacks, is the most extravagant form of maternity care in its expenditure of personnel. Thus, a team of physicians and several maternity nurses can give continuous care during labor and delivery to many women in a hospital during the time demanded by a single labor at home. Moreover, from the viewpoint of the safety of mother and child, it is preferable that a patient be delivered in the hospital even though she has to be sent home within 12 hours. This idea of maternity nurses delivering babies in the hospital is a new one in the United States but is part and parcel of this program recommended to meet the shortage of physicians. The development of such programs should be a joint enterprise between the local health department, on the one hand, and the local medical society or university department of obstetrics and gynecology if available, on the other.

But attention to our own mothers is not the only responsibility of the United States in maternity care. As the bonds between free nations become closer, agencies throughout the world, especially in Asia, are beseeching us for advice and personnel to promote their own maternity programs. Since about three-fourths of the world's births occur in Asia, the magnitude of the challenge is staggering. Here again the chief need is personnel. At a meeting of the Expert Committee on Maternity Care of the World Health Organization, held at Geneva in November 1951, the global aspects of maternity care were discussed in detail and it was agreed that the overwhelming need was facilities for the training of native midwives. A pattern for maternity care, under the conditions existing in Asia, has been developed in China by Dr. Marion Yang on the basis of some forty midwifery schools scattered throughout the country. That experience has served to stress the essentiality of the midwife in all public health programs for underdeveloped areas. To a greater extent than any other public servant she enjoys the affection and confidence of the populace, has an entree to their homes and,

if properly taught, is our most efficacious agent in enlightening the masses in regard to the rudiments of general hygiene as well as maternity and child care. The World Health Organization is seeking American nurses with advanced maternity and public health experience to help organize schools for the training of native midwives throughout the world. It is American nurses who are sought for the purpose, not midwives in the ordinary sense of that word, because it is believed that a broad background in nursing, in public health, and in social outlook is essential. But to equip these young women for such service it is mandatory that they receive advanced training in maternity care. They must know practical obstetrics.

Although the potential openings for American nurses with advanced maternity training are thus legion, two questions at once pose themselves: Where can nurses who wish to embark on such careers obtain training in clinical obstetrics as part of a program in maternity nursing? Can the necessary number of nurses be recruited?

Opportunities for such training in obstetrics, as part of a program in advanced maternity nursing, are practically nil in the United States. To develop them will require fortitude, because the whole scheme is contrary to orthodox thinking in this country. It will demand patience, because this is a pioneering effort in which misunderstandings are likely to develop and in which trial and error, at the start at least, must be the policy. It will necessitate furthermore, on the part of most obstetricians and some nurses, a complete revision of their attitude toward the functions of the nurse in obstetrics. But, in the light of the personnel shortage facing maternity care, and our changing concepts of the kind and quality of care required, who can name a feasible alternative?

What sort of training program is contemplated? It goes without saying that all candidates must be graduate nurses, matriculated in advanced programs of maternity nursing. The duration of the course in obstetrics which is included in this comprehensive maternity nursing program should not be less than 6 months. It should be under the direction and control of the obstetric staff of the hospital and with the cooperation of the nursing group. The number of students should be limited to such an extent that each student conducts not less than 30 deliveries during the course. The program of training would resemble an internship in obstetrics with certain exceptions: (*a*) The clinical work would be complemented, especially during the first months, by intensive coverage of the whole field of practical obstetrics, especial emphasis being laid on prenatal care, the conduct of normal labor, and signs of the abnormal; (*b*) a number of procedures, such as forceps delivery and general anesthesia, would not be assigned to the students. In order to make the training as useful as possible, however, she should be instructed how to repair spontaneous lacerations, to perform episiotomy and repair, to administer pudendal block anesthesia and should be allowed, under "scrubbed supervision" to deliver a few multiparous breeches. Yes, much of this is contrary to established custom.

Since March 1953 an experiment has been under way at the Johns Hopkins Hospital the purpose of which is: (*a*) to study the feasibility of training nurse midwives in a university obstetric clinic; (*b*) to evaluate the specific contributions which well trained nurse midwives can make to maternity care; and (*c*) to ascertain the role which nurses so trained can most advantageously play on the obstetric team. The project is being carried out in cooperation with the Division of Nursing Education, Teachers College, Columbia University. The trainees have appointments as "obstetric assistants." This designation was chosen because it more nearly connotes than any other the main function which we would envisage for such nurses; namely, the rendering of skilled assistance to obstetricians. In vast rural areas of this country and in understaffed hospitals, this skilled assistance may also include the conduct of normal deliveries but never without the supervision and control in absentia, of a readily available obstetrician.

In the first 6 months 2 nurses were selected who had completed the course in Advanced Maternity Nursing at Teachers College, Columbia University and the course in Nurse-Midwifery at Maternity Center Association, New York City. These nurses gave complete antepartal, intrapartal, and postpartal care to 85 mothers, under the supervision of the obstetric staff. Our experience during this time was so gratifying in every respect that a 6 months' course was begun on October 15, 1953, for nurses who had completed the course in Advanced Maternity Nursing but who had not had previous midwifery training. The students receive instruction and guidance from the 2 obstetric assistants who continue to work under the supervision and control of the obstetric staff.

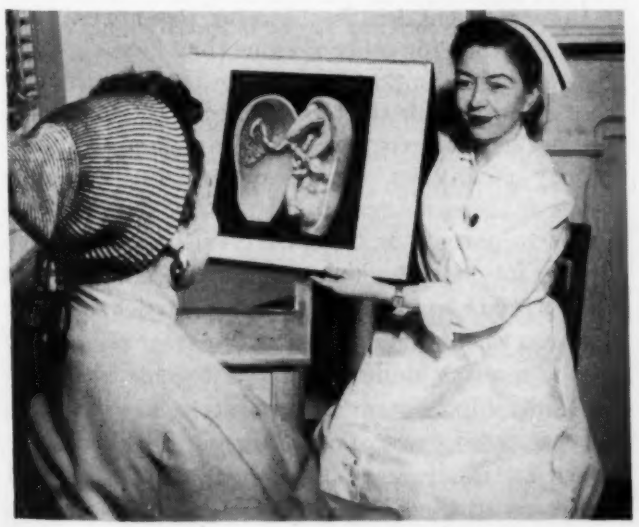
Although we still consider that this program is in the experimental stage and avow that we have

much yet to learn, we are convinced, on the basis of close observation, that nurses with this type of advanced training have unique and urgently needed contributions to make to maternity care. Quite apart from the expected shortage of physicians, mothers everywhere stand to benefit from the meticulous, sympathetic, and highly personalized attention which such nurses are able to render throughout pregnancy, labor, and the puerperium. By training, temperament, and outlook, they are singularly fitted for this important mission. This is their transcendent raison d'être.

The problem of recruiting a sufficient body of qualified nurses to make this project worthwhile, may or may not prove difficult; and limiting the group to eligible candidates from the advanced maternity nursing programs will involve less rapid expansion, but their competence will be recognized and the quality of care safeguarded. Despite this country's 365,000 active nurses, there is a critical shortage; and it is estimated by the President's Commission on the Health Needs of the Nation that the shortage for the country as a whole in 1960 may exceed 50,000. On the other hand, this figure means that the ratio of nurses to population in 1960 will be a little higher than we have at present. Moreover, the program envisioned for these maternity nurses offers such unique responsibilities and such rich opportunities in various spheres that it promises to attract a full quota of well prepared candidates. As in other clinical fields such as psychiatry, the profession of nursing will maintain its position by qualifying its members for increasing responsibilities.

Many other problems facing maternity care now and in the future will doubtless come to mind, but most of these center, in the last analysis, on this same crucial issue of personnel. For example, more hospital beds are urgently needed since ideal maternity care demands a 10-day hospital stay. To attain this objective in many localities, new hospital construction will be necessary; but in countless other areas, where the shortage of maternity beds may be equally dire, large maternity units are closed down because of insufficient professional personnel. There are plenty of beds, but no doctors or nurses. In this connection it is important to recall that the maternity nurses of the type we have in mind can function, if need be, as competent members of the clinical obstetric team as well as administrators, supervisors, or teachers, of maternity nursing care.

Dr. Eastman's "obstetric assistants" assume responsibility, under medical direction, for the care of a mother throughout her antepartal, intrapartal, and postpartal experience.



The most prevalent criticism which European obstetricians and midwives level at American maternity care is our assembly-line method of managing patients, especially the fact that they are often left alone throughout most of labor. This lapse is even cited as evidence in favor of home delivery. It is pointed out that parturients at home are never left alone and that they are amid familiar faces and surroundings with the result that apprehension is minimized; and, as apprehension is minimized, labor becomes more physiologic with a lower incidence of uterine inertia. There can be no question about the general validity of this criticism. The lesson to be drawn from it, however, is not that we should elect to go back to home deliveries but that the psychological advantages of home delivery should be brought to the hospital. This emphasizes again the need for the type of maternity nurse which we have visualized.

Given competent personnel in sufficient quality and quantity other problems dwindle in significance because such personnel can be counted on to resolve whatever other difficulties arise. The vast strides made in maternity care during the past few decades are attributable to many factors, but the transcendent factor has been a network of thoroughly trained obstetricians and nurses. This army of workers did not develop by chance but was the purposeful and far-sighted creation of various agencies intent on meeting the recent needs of maternity care. Let us hope that the crucial problem of future personnel will be handled with equal wisdom and success.

how do we train for

LEADERSHIP IN PARENT EDUCATION

GUNNAR DYBWAD, J. D.

Director, Child Study Association of America

IN HER PAMPHLET, Children Living in Their Own Homes,[1] Annie Lee Davis draws a challenging picture of the widening horizon of child welfare programs. In outlining social services that should be available in each community she stresses those insuring healthy growth and development in children, which are extended to parents before difficulties arise. While she includes many aspects of what is known as family life education, this article will review specifically her suggestion that child welfare agencies make it a staff function to organize and lead parent education groups.

This is not the first time a claim has been made by the welfare or health field that parent education groups may be considered a professional responsibility within its sphere. Family welfare agencies, neighborhood houses, hospitals, and public health nursing groups have demonstrated by their activities their interest in this area over a number of years and increasingly so within the very recent past.

It therefore seems appropriate to define what is meant by parent group education and to explore content and methodology as well as the added professional skills, if any, required for this activity.

The specific focus of this article is on parent education groups, using the discussion method, in which parents come together for a series of meetings. Such groups have been in existence since before the turn of the century. These first groups, while few in number, nonetheless had great significance because they represented an early recognition on the part of "just parents" that they had a need to learn more for themselves about the responsibilities of raising children. In the historical files of the Child Study Association of America are minutes of parent groups meeting in the 1890's which record in detail how they struggled by reading together and discussing Rousseau's Emile so that they might gain from his knowledge better understanding in coping with their problems as parents.

From those early beginnings parent groups have multiplied to the point where now there is hardly a town in this country that does not have one or more groups of parents meeting together for the specific purpose of learning more about their children. So great is the variety of auspices under which these groups meet that it is scarcely possible to arrive even at an approximate estimate of their number. Nor is this the only unknown factor, for these groups differ so substantially in their objectives that they cannot be characterized in common terms. Their variations today serve, in fact, to demonstrate the evolution of methods for such groups from the use of classical books as guides, to instructional lectures by experts, to the use of group discussions, and then, under the impact of dynamic psychology, to an increasing emphasis on the group process. All these approaches can still be found in use today.

In more recent decades, however, parents have also come together for other reasons than "child study." It is therefore important to state that for the purpose of this article the term parent discussion group will not include group efforts toward improved community conditions, or assessment of community needs, or those designed to interpret community programs to parents or to assist them to assume community jobs, all of which are of vital concern to the child welfare worker. Nor can this article consider the overwhelming number of parent discussion groups meeting under what has become known as lay-leadership, a term incorporating a wide range of types and degrees of competency, which naturally reflect on the groups' programs. These lay-lead groups constitute a major movement in this country,

PARENTS ARE TARGETS for many darts these days by lovers of scapegoats. It is time that more thought be given to how parents can be helped, rather than ticketed as failures. As managers of what Dr. Brock Chisholm has called "the biggest business in the world, the business which outweighs all other values: the rearing of children," parents as a group merit far more of a hand than they are now getting. Programs of parent education increasingly are demonstrating their usefulness in deepening parent understanding of child behavior and in enriching parent-child relationships. This author sees many kinds of professional workers taking leadership in this movement, provided they have the requisite specialized training for this work. Here he emphasizes the possibilities for one group, the well-trained child welfare caseworker.

whose focus and method deserve careful evaluation. How agencies in the health or welfare field should relate themselves to them does not fall within the framework of this article.

In thus limiting this discussion to parent education groups meeting over a period of time under professional leadership we find that recent efforts to define this activity reflect confusion or at least sharp divergencies of opinion within the professional field.

In its pamphlet, Scope and Method of the Family Service Agency,[2] the Family Service Association of America speaks of (parent) group education as "activities in the interest of disseminating knowledge about human relationships and social adjustment." This seems to signify a didactic approach. Irving Brodsky [3] defines parent group education as "group counseling . . . a method of family life education which draws on the techniques of discussion leadership, to teach individuals in a group setting knowledge and skill in family relationships. . . . It is an educational process aimed not at treatment but prevention of disturbance in personality or family relationships."

However, in their paper Casework in Small Group Settings,[4] presented at the 1953 National Conference of Social Work, Grunwald and Greving define the term group counseling as "an application of casework methods within a group setting" with reference to a group of clients who have come to the agency for help with specific problems. Thus it appears that the word "counseling," which has been used to define social work activities in other contexts as well, does not serve to clarify the scope of parent group "education."

More helpful toward clarification have been efforts to crystallize distinguishing criteria by differentiating group education from group therapy.

Dr. Peter Neubauer has pointed out succinctly that group therapy directs itself to the deviant aspects of personality, the symptoms or the character disturbance, using a specific technique to effect a change in individual pathology. Group education, on the other hand, is oriented to the healthy factors of the personality with the goal of helping parents to gain an understanding of themselves and their children, and an increased capacity to make their own choices on the basis of such understanding. Thus group education is to be understood as a dynamic learning experience which goes far beyond intellectual absorption of new knowledge through a didactic process, since it actively involves the feelings and attitudes of the group members.

"Under skilled leadership, parents are helped to share their thinking and feeling about their common concerns, to examine the meaning of their common experience and to build on their inner strengths as they take on a more integrated parent role." [5]

A further clear methodological distinction lies in the fact that, in contrast to group therapy, parent group education does not aim to explore unconscious motivation nor to solve specific problems of a parent in the group, even though specific parents' experience will be utilized to focus on general concerns of the group. Each of these two approaches, group education and group therapy, has its own objective methods and procedures which can operate side by side in the same organization.

These necessarily brief comments on the nature of parent discussion groups point up why this is an area of function for the professionally trained leader. However, the existing confusion in the professional field as to the nature of parent group education is matched by a resistance on the part of some parents to recognize this need for professional leadership.

The Fact Finding Report of the Midcentury White House Conference, Personality in the Making,[6] has a revealing section, The Family and the Experts, which emphasizes the increasing number of new sources of help for young parents which replace or supplement such traditional advisors as the family doctor and the family friend. Many parents find themselves overwhelmed by the "expert" advice on parenthood and child rearing which is coming to them today through an ever-increasing number and wide range of channels, such as newspapers and magazines, television, parent teacher organizations, guidance counselors, well baby clinics, and community agencies. It was in recognition of this fact that the Child Study Association of America held its 1952 conference on the theme "Parents in Search of Self-Confidence." At this meeting, Dr. Frederick C. Redlich,[7] in a talk on Parents and Experts, emphasized the responsibility of the professional in his relations with parents, lest efforts at helping parents actually result in increased anxiety.

This is a significant point, particularly in considering its application to the professional leader's function in parent discussion groups. What in his knowledge has general applicability and where are the limits of his "authority"? Here again we find a divergence of prevailing opinion as to the degree of leader activity. One viewpoint from the family agency field sets forth as the leader's responsibility "to develop sound and generally accepted concepts of attitudes and behavior. . . . The discussion leader represents an ego ideal to the group and should embody accepted standards. The role of the leader is to be allied with the strivings toward meeting social demands." [8]

From the group work field comes the suggestion that the leader of such groups is the transmitter and interpreter of positive cultural ideals and values. This raises the query as to who determines these values and ideals and accepted standards. W. L. Kindelsperger, in discussing at the 1952 National Conference of Social Work some aspects of "new" leadership function in adult education, stated: "I sometimes suspect myself and other persons who are professionally concerned with group processes and leadership in that we may be subconsciously preoccupied in trying to find controlling positions from which we can work under democratic forms." This caution is particularly appropriate in a nation with such a wide range of ethnic and religious groups and a correspondingly great variation of cultural patterns. Indeed, it is this range of variation which makes it important in our country to have free discussion groups where parents do not meet an "authority" but rather a catalyst and interpreter who can help them to understand their children's developmental needs, to recognize their own goals as parents,

and to work out their own solutions from an awareness of existing differences, as well as similarities, in our society.

What kind of training, then, is indicated to prepare the child welfare worker for an assignment of leading a parent education group? Again, we find wide disparity of opinions. Some feel that "mature and experienced caseworkers can acquire the necessary knowledge and skills through supervised practice of this kind of work." [9]

Others feel that the one missing link in the caseworker's preparation is "some understanding of group dynamics as applied to methodology." [10]

Other suggestions add to this training in group dynamics a limited amount of "in-service training." This raises, of course, the question as to what is meant by this requirement of knowledge of group dynamics. Kindelsperger warns about the possible dangers of an overemphasis on techniques per se, stressing that the important new elements in the adult education field have become overshadowed by devices such as "listening roles," "feed-back," "buzz sessions," and "role playing." There is much evidence that such a development has taken place in the field of lay leadership of parent groups and there is sound basis for Dr. Kindelsperger's caution with regard to professional leaders as well. Group dynamics, indeed, has a major contribution to make, but it needs to be put into the context of the total job of the parent group leader.

Still thinking in terms of the caseworker, including the child welfare worker, primary consideration must be given to the worker's readiness to deal with the content of parent discussion groups. In the

light of our earlier statement, that parent discussion groups address themselves to the healthy aspects of personality, toward a better understanding of children's needs, within the setting of normal family living, we must ask to what extent such material is included in the training of caseworkers.

While all schools of social work provide for a sound introduction to the principles of mental hygiene, it has been the experience of the Child Study Association of America, in providing training as parent discussion group leaders for two successive groups of graduate social workers, that these trainees recognized the need for content additional to what material they could draw on from their professional training and experience. This is not surprising when one considers that in the setting of parent discussion groups, the leader must relate his material in a significant way always to the parent, who in turn will utilize what he gains by coming to a better understanding of, and more helpful relations with, his children.

The following are some areas in which the caseworker would need to have expanded knowledge in content:

1. The development of children in normal family living, with particular emphasis on the similarities and differences in their stages of growth and patterns of physical and personality development.

2. Awareness of the effect of parenthood on husband and wife individually and in their interrelationship.

3. Appreciation of factors making for mental health and a diagnostic awareness of them, since the basic goal of parent education is to build on strength in the individual parents.

4. Cultural factors affecting patterns of family living and the readiness of the parent objectively to review such patterns.

In addition to these considerations regarding content, two areas of methodology would require special preparation of the caseworker:

1. The new concepts of learning which have developed in recent years with reference to adults and which emphasize feelings and attitudes as much as intellectual ideas. Here, again, are some factors of particular import with regard to parents.

2. A knowledge of the dynamics of group process including the leader's role in helping the group to define and achieve its goals within the framework of the agency's program and purposes.

The foregoing refers to material which would appear in a training plan, on a lecture and seminar basis, as part of theoretical instruction. That this needs to be supplemented by field experience would appear obvious in the professional realm of social work which has always observed the closest integration between learning and doing. Fortunately, unlike either casework or group therapy, there does not exist the problem of confidentiality or delicate interpersonal relations to prevent observation of parent discussion groups by workers-in-training. As part of the step bridging the gap between theory and practice such observation has been part of the Child Study Association's training program for leaders of parent discussion groups for several years without objection from the parents, who are quick to accept the explanation of the reason for the presence of (silent!) observers. The opportunity of observing an ongoing group, from its first to its last meeting, gives the worker-in-training a live picture of the interaction of the group and leader as well as of the development of content by a specific group. Coupled with seminar discussions, it will go far to ease a worker, whose previous practice has been limited to individual contacts, into his first experience as a parent group leader. The trainee is then readier to go on to his field work and it hardly needs to be emphasized that this should be supervised experience.

This recital of desirable training requirements may appear too imposing and to some, perhaps, too exacting for as modest and as supplementary an assignment as the leading of parent groups would constitute in most agencies. But how else can we expect a worker to function in sufficient accord with this picture that Jerome Frank [11] draws of a parent group leader: "The role of the leader in a free discussion group is very different from that in a lecture or study group. He is less the authority and more the catalyst and interpreter of interaction between group members. His task is both to awaken and to shield the participants, to maintain a supportive neutrality with respect to all sides of an argument, to help members to focus on significant issues and fully explore their attitudes. The demands on his poise, sensitivity and skill in human relationships are great."

What has been said in this article about the need for special training for the child welfare worker doing parent education applies, with appropriate modifications, to other professions that work with parent groups. These include, among others, practitioners in other social work areas, psychologists, educators—including religious educators—and public

health nurses. Much further exploration is needed to determine to what extent training in those professional fields needs to be supplemented for adequate preparation for parent group education.

Parent group education is no panacea. While potentially it can do a far-reaching job in prevention, it is a professional service, as outlined here, and must be developed carefully with due regard to the availability of adequately prepared personnel. Still, it will make an increasing contribution to meet the challenge Annie Lee Davis puts forth in her pamphlet, Children Living in Their Own Homes:[1] "Present day knowledge of children's needs and good child rearing practices should be easily accessible to all parents and available in such a way that it becomes incorporated into their thinking and feeling. The all-important task of child rearing can no longer be left to chance."

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[1] Davis, A. L.: Children living in their own homes. Children's Bureau Publication 339. Government Printing Office, Washington, D. C., 1953. 52 pp. (20 cents.)

[2] Family Service Association of America: Scope and methods of the family service agency. The Association (192 Lexington Avenue), New York, 1953.

[3] Brodsky, I.: Group counseling and school group work. The Group. February 1953.

[4] Neubauer, P., M. D.: The technique of parent group education. *In* Parent group education and leadership training. Child Study Association of America (345 East 46th Street), New York, 1953.

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[6] Witmer, H. L. and Kotinsky, R.: Personality in the making; the fact finding report of the Midcentury White House Conference on Children and Youth. Harper, New York, 1952. 454 pp. (pp. 207–9).

[7] Redlich, F.: Parents and experts. Child Study. Summer 1952. pp. 10, 11, 29.

[8] Pollak, G. K.: Family life education; its focus and techniques. Social Casework 34: 198–204. May 1953.

[9] Taggart, A. D. and Scheidlinger, S.: Group therapy in a family service program. Social Casework 34: 378–85. November 1953.

[10] Meyer, M. S. and Power, E. J., Jr.: The family caseworker's contribution to parent education through the medium of the discussion group (Reprint). American Journal of Orthopsychiatry 23: 621–28. July 1953.

[11] Frank, J., M. D.: How parents learn. *In* Taking stock in parent education. Proceedings of the 1953 Conference for Workers in Parent Education. Child Study Association of America (345 East 46th Street), New York, 1953.

IN THE PERIODICALS

The December 1953 issue of ***Childhood Education*** is given over to "Children's Time." Among the many aspects of the subject considered are: the child's own concept of time, which is different from the adult's; the teacher's problem of how to use the child's time—"There never is enough of it. How can you be sure you are using it in the best way?"; and foreign comments on the characteristic American attitude toward time—"In America, everybody and everything seem to move as fast as they can." "People seem always to be in a hurry getting places and getting things done." But, surprisingly, "I could not trace impatience in the Americans despite the fact that they always seem to be in a hurry."

A study of maladjustment and maternal rejection in retrolental fibroplasia made at the Perkins Institution and Massachusetts School for the blind is reported in the October 1953 issue of ***Mental Hygiene.*** The authors found that: "Almost every rejected child was poorly adjusted. The converse also was true. All of the children whose mothers accepted them were well adjusted at school. Predictions regarding success or failure at school might have been made on the basis of whether or not children had been rejected at home; such a prediction would have been correct for fourteen of the fifteen children." The same issue carries articles on children's reactions to physical defects and on consultation service to public schools by a mental health team.

The UNESCO ***Courier*** for October 1953 is devoted to paintings and drawings by children. There are forty illustrations showing the work of children in Japan, China, India, Israel, Egypt, Nigeria, the Sudan, as well as half the nations of Europe and the Americas. The numerous articles include one by Henri Matisse on "Looking at life with the eyes of a child."

Scandinavian children's books are compared for quantity, appearance, and content with children's books sold in the United States and Great Britain in the Autumn 1953 issue of ***The American Scandinavian Review.*** "In proportion to population," the article states, "probably more children will receive more books in Sweden this year than in any other country in the world."

The ***Quarterly Review*** for October 1953 contains an article on the role of the school in preventing juvenile delinquency. School organization, school attendance laws, class size, curriculum content and many other factors are considered in their effect on an adolescent's ability to find a socially acceptable place for himself in the world today.

Volume II, number 3, of ***World Theatre*** (published under the auspices of UNESCO) is devoted to the theater and youth. It is profusely illustrated with scenes from theatrical productions by or for children. The articles cover a variety of subjects, such as the children's theater in Great Britain, the theater for adolescents in Denmark, and creative and formal dramatics for school children.

In the summer of 1953 a camp for children 9 to 14 years of age was held at Imperia, on the Italian Riviera. The children represented 16 nationalities, 11 languages, and 6 religions. This camp is described in the November 1953 issue of ***Freedom and Union*** and the October issue of ***New Era.***

research into the behavior of a few holds promise of greater understanding of all children

CHILD STUDY IN A NEW SETTING

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IF ONE WERE TO MEASURE research accomplishments on the basis of a 24-hour day, he might well say the time is at least noon so far as the physical sciences are concerned, but it is still early morning in mankind's efforts to delve into the vast and intricate depths of his mental apparatus.

Any research which might possibly move us even a minute ahead in our understanding of the human mind and its effect on body processes, reactions and stimuli, is therefore potentially time gained, even though the hours still to be spanned may seem endless.

In this paper I would like to discuss the efforts now being made at the Clinical Center of the National Institutes of Health to budge time at least a few seconds ahead in our understanding of the human mind as it is reflected in the emotional disturbances of children.

Challenging is an overworked word, but it is certainly applicable to the task that faces those working on this project, still in its infancy at the Bethesda, Md., Medical Research Center.

The members of the staff, chosen for their particular aptitudes in working with children, had not only to decide upon the best methods to use to study and treat the children; in addition, from that vast body of what is not known, they had to choose those research goals which would meet the dual standard of reachability and vast application for others who work with children.

In these choices, we had to bear in mind the limitation which the setting of a large research hospital put upon us. Children can be decontaminated to a high degree from the feelings which a large hospital may produce in them. But the percentage of possible disinfection is not 100 percent.

To illustrate: a child with a physical upset, such as appendicitis, may react quite well to being hospitalized, because he knows hospitalization will make him better. But prolonged hospitalization, past the point where it can make a real contribution to his recovery, is fretful to him.

A child who is emotionally disturbed but who improves beyond a certain point should not live in a hospital ward. We recognize the need for an in-between in the course of treatment such as might be possible in cottage living, where the gap between psychiatric hospital and family or foster home in the community could be bridged.

Another consideration which went into our early planning was that the whole staff needed to be exposed to normal children, so that we would distinguish clearly behavior typical of an age group from behavior that is pathological.

For people who deal with disturbed children do have a tendency to focus on the pathology of disturbances, and to forget what is normal for a kid of a certain age. Anybody can legitimately be expected to be considered normal even though he has some peculiarities. Some adults, for instance, are afraid of mice. Some children have an irrational fear of the dark but still are normal children.

There was also the question, and a large one, of how much "trying out" we could do, once we had children with emotional disturbances as our patients. We thought it essential to "try out" a program with normal children, who, if we didn't hit it quite right, would tell us we were off. The healthy personality will defend itself against illegally high doses of boredom. If disturbed children were exposed to the same thing, they would get so disorganized it might be dangerous.

And so we arranged a trial run, before accepting any patients, to see what the research set-up looked like with children in it.

Physically, the ward is laid out around several general rooms, with living quarters arranged for two children to a room with bath. The general rooms include a large play or "day room" with tumbling mats, ping pong table, toys, books, radio, record player, and other devices. The lounge room has a television set. There is a room for arts and crafts, and for woodworking, and there are two schoolrooms. Apart from the ward itself, there is a sun deck, which can be used for roller skating, and a large gymnasium and auditorium, which is shared with the study patients in other research programs.

To try out this ward, we borrowed children for 2-week periods from an elemenary school in the neighborhood, and from welfare institutions. We asked them to come for a 2-week stretch of "camping," live on the ward, and tell us what the place should be like. We told them it would later be a hospital, and we wanted their advice on what toys and activities should be planned so that when children came as patients, they would have a good time.

These "research volunteers," as we called them, came in groups of from 8 to 12 for 2-week periods. We took both boys and girls, ranging in age from 6 to 14, and from different racial groups.

It was important to make our "research volunteers" see the "camping" as a 2-week interlude with a definite ending time. But even though both those who sent the children and the staff on the ward went to great effort to explain this, the children showed a disappointment reaction when they left which was out of focus with their verbalized acceptance of the short duration of the "camping." Some of them reacted by hanging onto doorknobs, hanging back when it was time to go.

It was interesting to watch the ways by which these children acted out their reaction to the hospital atmosphere. The first group of normal girls started their play activity by bandaging themselves, so as to shock their mothers when they came visiting. The hospital atmosphere seemed to provoke this or some other form of acting out, despite the fact that none of the staff was in uniform, and we avoided all semblance of a hospital in the ward itself.

Indeed, our staff members, for the period of the "try-out," laid aside their professional identifications. Instead of psychiatrists, psychologists, nurses or attendants, they became counselors, working together in teams. They were exposed to the different age ranges of children and were able to discuss freely with each other their observations as the program was developed.

The program was planned by the staff in a council meeting with the children, who made suggestions on daily routine and special activities, and whose reactions to what had gone before were welcomed.

On the basis of our trial run, we were then ready to accept our first patients. We had a staff equipped to handle up to ten disturbed children at a time, numerically large enough to have four supervisory people on the ward at all times. This includes psychiatrists, research psychologists, a teacher, a caseworker, a group worker, and members of the nursing staff.

The disturbed children who come to us may be referred by physicians, clinics, social agencies, from anywhere in the United States, although in these beginning months, we are limiting our patients to the nearby area. As do other programs in the clinical center, we attempt to give our patients maximum study and treatment within the limits of what is known during their stay at the Center. The Public Health Service's center for medical research provides the seven national institutes of health—mental health, neurological diseases and blindness, cancer, heart, dental research, microbiology, and arthritis and metabolic diseases—with resources for both laboratory and clinical investigation of the important diseases of today.

In our first studies, we are attempting diagnosis and treatment of children with extreme aggressive and destructive tendencies; children who, although in apparent physical health, have, by their attempts to act out their aggressions or their problems, been frequently hard to care for in the normal community life or in an institutional setting.

We start with the basic premise that not everything is wrong with these children. It is part of our job, and an important part, to assess what is right with them, and with this knowledge, attempt to find out what kind of treatment they respond to best. Our findings will go back to the referring physician who will work with these children when they return to their home communities.

In addition to the activity programs which our "research volunteers" helped us formulate, the children now at the Center as patients have a daily interview hour with a psychiatrist, who takes an active part in the ward life. Most of the children are

getting academic coaching on a "remedial" basis or attending regular classes at the center.

Our experience so far has shown us that there may be definite value in what might be called the "marginal interview." The psychiatrist who is giving individual therapy to a disturbed youngster may see him only during a regular weekly visit, and may find him unresponsive during the normal treatment period.

Youngsters, especially those at an early adolescent age, may find the idea of sitting in a room and talking to an adult about their problems quite unbearable. But many of these children are quite capable of revealing by their play activity what is going on inside them. They may find it quite natural to talk to an adult about things which happened in a game just finished while they are still "hot." They may have a blowup, a temper tantrum, which they are perfectly willing to talk about when it happens, but which might be forgotten by the time their regular weekly interview comes around.

At the Center, our psychiatrists can take advantage of this "marginal interview" opportunity when a youngster exhibits some unusual behavior or shows some upset, either in play activity or at some other time. The timing, in talking about things just after they happen, seems to be very important.

As mentioned earlier, in discussing research goals, we attempted to choose those which seemed reachable and widely applicable. We are presently concentrating on finding the answers to four questions which we believe meet these criteria:

1. Can children work out their problems through arts and crafts, day dreams, fantasy, or do they have to act them out in reality? Some youngsters can use a revenge fantasy; others have to bite, hit, kick, throw things at anyone at hand, even though that person has nothing to do with their frustrations. For one boy, even the mild physical discomfort of a sore throat will bring on an attack on adults who "made my throat sore for me."

2. What is the nature of group excitement that causes loss of controls? It seems important for practitioners, both teachers and parents, to know how controls in children are developed, and how they can be cemented against breakdown under stimuli. Many children—both those normal and those who are disturbed—have a reasonable amount of control over their emotions and impulses, and can be considered well integrated in this regard. Some, when exposed to excited group situations where everybody else begins to act wild, lose all sense of proportion. Their ego controls melt like a chocolate bar in the hot sun.

"Symbol of man's untiring search for knowledge and a better life," the Public Health Service's Clinical Center towers above the buildings that house PHS's 7 research institutes, all of them located at Bethesda, Md., a suburb of Washington, D. C. Dedicated on July 2, 1953, the Center provides 500 beds and double that amount of space for laboratory work in basic and clinical research into major types of illness. Dr. Redl's headquarters are on the fourth floor.

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This form of "group psychological intoxication" is comparable to the way adults may act when they go to a convention in somebody else's town. It is important to understand the factors which loosen or negate the control mechanism.

3. What happens to adults when they are exposed to the behavior of disturbed children? One skill which the teacher, the child worker, and the parent need is the ability to cope with the emotions and anxieties which are created in them by exposure to disorganized behavior in a child. What experiences in the adult's own life predispose him most favorably to work skillfully with children, of what ages? This becomes especially important when advising an individual on the choice of his professional career. It is also important in the choice of that person with the best professional equipment for work with a given kind of child in a given age range.

4. What children benefit from "treatment homes"? Over the last decade, interest of communities in developing "treatment homes" for children with severe behavior disturbances has grown by leaps and bounds. Yet little is known about which children benefit most from such arrangements. The possibilities of observation which the clinical setting offers should help us to develop more conclusive criteria for referral to treatment homes than we now possess.

When we arrive at findings in these four areas, we will have added a little to the skimpy body of scientific knowledge on the treatment of disturbed children. But for every question answered, a dozen unanswered questions turn up, like dragon's teeth, to plague us.

I would like to mention a few areas—although by no means an inclusive list of them—where there is demonstrated need for research.

We know relatively little about ego disturbances, about children with terrific control breakdowns.

We have not isolated the influence technique, the degree to which an adult can handle a problem child skillfully by the way in which he does things to or for the child.

All pictures of children on these pages were posed by members of the Center staff and their families in typical clinical situations. Dr. Redl and the child of a staff member have the kind of private chat that would take place between a psychiatrist and an emotionally disturbed patient.

Children under treatment at the Center are not separated from staff members even at mealtime. At least one staff member sits at each table. Meals are carefully planned under supervision of a nutritionist. The window in the background, not used for observation, opens from the nurses' station.

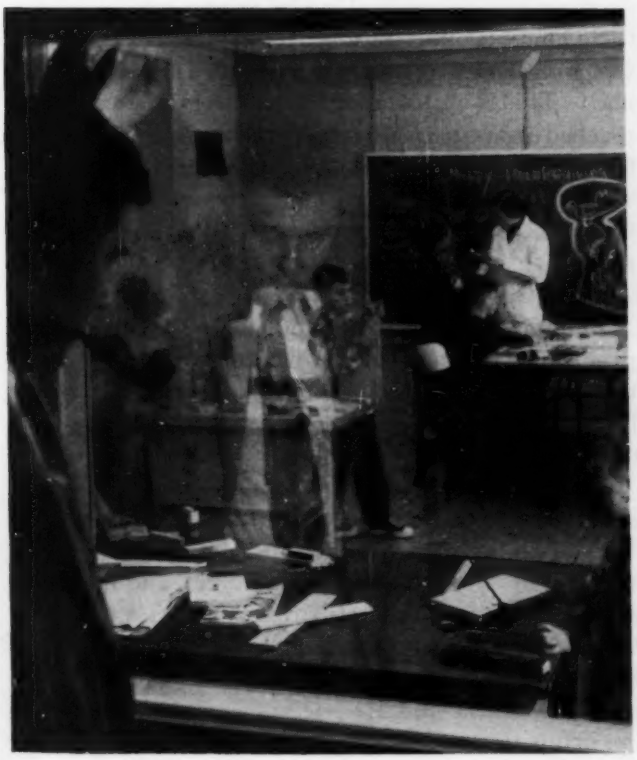
We know less about extreme aggressive behavior in children than we do about anxiety neuroses. This kind of behavior often eludes study because people experience so much difficulty in living with an aggressive child. One of the most neglected aspects of normality is the study of the amount of aggression which a child may need in order to survive in the community and under the cultural demands in which he lives.

Politeness, as an example, is a characteristic which has quite different meaning in different subcultural classes. I remember life in a rather fancy boarding school where I was puzzled by the amount of politeness which some of these youngsters threw at me. Whenever I came to the dining room, they would line up, yank open the door and let me float in like the Prince of Wales, offering me on a platter the kind of automatic respect which otherwise one would not expect to get without battling for it heavily. In this case, hyper-politeness was meant as a compliment related to the caste and class difference between the children themselves and the teachers.

Switching from there to a camp with rather aggressive youngsters from tough and disorganized neighborhoods, the phenomenon of politeness assumed an entirely different meaning. For those youngsters, being polite meant "That's the way you treat a guy you don't trust." You are polite to an enemy. To the degree to which one is acceptable, he doesn't have to run around in a psychological tuxedo all day long.

To continue with the areas where research is needed, we do not know enough about the impact of toys, games, and activities on children. Many ordinary children's games have the mechanics of wisdom built into them. Children who play them can discharge a certain amount of aggression without feeling guilty. The game "code" takes care of the excitement, without letting the activity get out of hand. In circle, running, and chasing games, some youngsters who come from tougher backgrounds have trouble, at the start, because the idea of being

One-way glass permits staff members free observation of the children in the classroom, at play, and as they work in arts and crafts. The children are told the glass is one-way, but are not told when they are being observed. These play-acting children seem undisturbed by their observer.



Disturbed children often are unwilling or unable to talk over their problems in a formal interview with a psychiatrist. Both to observe, from their play, what is going on inside these children and to be on hand when sudden blow-ups make talking easier, the staff takes part in all group activities.

chased by another child without retaliating immediately is equivalent to losing face with the group.

On the other hand, some anxious children can afford to express some mild aggression in such games without the fear of retaliation because the game "code" demands that one be a good sport. This is why most games have a "safe" place to which players can return with impunity when they become either too anxious or too excited to go on.

But we do not know which daily diet of activity program is healthiest and which, when engaged in even for the time being, may lead to overexcitement, breakdown, and confusion.

Yet it should be possible to select game materials for disturbed children so as to bring about better balance in the child's total life experience, without the risk of overstimulation or distortion of that experience.

We need to know how to differentiate more carefully between what is neurotic or schizophrenic behavior in a child and what looks like such behavior but is age-typical. Behavior that is in line with the developmental phase of the child's growth and is age-typical need not concern us. For instance, almost all children crawl on all fours at one age, but nobody gets excited about it.

We need to develop better criteria for predicting in earlier years the problems which may occur later. We need to differentiate between the things kids do which have no latent significance and others which may be called "cute" at one age but may be the beginning of later difficulties.

We need to clarify the connection between emotional disturbance and the learning process. At the present time, we have often made this an either-or business. Either we concentrate on the child who is emotionally disturbed, and try to straighten him out with remedial learning aids, or we concentrate on remedial education and ignore the emotional disturbance. It would appear that there is a submerged relationship between these two factors, and the attack on them may have to happen on both sides simultaneously.

Also unexplored is the question of how a group should be formed for therapeutic purposes. Which children should be put together in a given group at a given time? Quite often the behavior of some children is so overexciting or anxiety-raising for the others that their presence in the same group actually jeopardizes the treatment of everybody else.

On the other hand, quite often children supplement each other quite supportively, once they are well into a group, and they can function with much less disturbance than the history of any of them would have led us to expect.

In suggesting these areas for research into the pathology of the disturbed child, it is well to remember that the normal is also important.

So many people consider it unnecessary to do anything once a given piece of behavior is declared normal. This is quite out of line with the state we have reached in medicine. A tonsillectomy is considered to be rather a normal experience in a child's life, yet we would not relegate it to a person who is not trained to do it; we would not consider it silly to protect the person against damage or infection while he goes through it.

The fact that we consider such handling of a problem still a normal problem does not have anything to do with how seriously the problem should be taken, how much attention it should get, or what quality that attention should be.

In the field of human behavior, we don't seem to have reached an equal state of reality awareness. Very often by labeling something abnormal, we think we have to sail at it with all our forces, and by labeling something normal, we think it now isn't important anymore, that it is silly to pay any attention to it. In this way we are missing some of our most important therapeutic, as well as preventive, opportunities.

Uniforms are worn by none of the staff. Here a psychiatric nurse and two children inspect the aquarium in the children's ward.

Among the youngest of the health professions, medical social work has been one of the most persistent of all in evaluating its practices, examining its directions, and emphasizing its relationships with other members of a professional team. Large credit for this must go to the author whose past studies have been milestones in the development of social work.

PERSPECTIVES IN PUBLIC HEALTH SOCIAL WORK

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THE TIME HAS COME when public health social work needs to be examined from the perspective of the past, the present, and the future.

It will be recalled that in the late 1930's medical social workers as a professional group had completed their exploration of the hospital setting and had clearly defined social casework as the central function of the hospital social service department. Barely had this step been taken when new trends created new issues and carried us into a new cycle of professional development. The two major factors in this seem to have been psychosomatic medicine, with its deepened understanding of the individual patient, and public health programs, with their emphasis on service to large population groups. Both developments stressed multidiscipline activity and made it imperative for medical social workers to redefine their contribution. At the same time social work as a whole, previously focused on social casework and divided into many specialties, was moving toward a more comprehensive, unified, basic professional approach.

Thus, about 17 years ago, medical social workers were being drawn out of hospitals into broad programs where they had to face new situations, learning and exploring as they went along. From our present perspective, we can see that the situation was far more complex than we then realized. Alternatives had to be faced and judgments made at a time when principles were not clear. It is my impression that we are just beginning to arrive at the point where we can see the rationale and obtain more control in this rapidly changing situation.

The significance of our successive efforts to explore, analyze, and evaluate public health social work can now be better assessed. In the first phase we recognized that we had to move beyond social casework but we were aware that this still had an important place in public health social work. Thus the early movement toward "consultation" is understandable and important. The first attempt at a detailed analysis of functions and processes, undertaken by a study committee of the American Association of Medical Social Workers between 1946 and 1951,[1] could not get as far as we hoped toward clarification of function but was a valuable contribution. The analysis was sound in showing the full range of the medical social worker's activities more clearly than had been seen in the hospital situation. It enabled us to grasp more intelligently the comprehensive nature of the service and the total picture of what medical social work might bring to a health program.

The next effort to analyze public health social work was undertaken under the auspices of the United States Children's Bureau. This came about as the result of many years of joint thinking between Federal and State medical social consultants, culminating in an intensive workshop held in Washington in June 1951. The report which grew out of this workshop, Medical Social Services for Children,[2] represents a very real advance and clarification of our thinking. This analysis enables us to visualize all the activities as part of one professional job, to see medical social work as a whole. Social work texts traditionally devote one chapter to each field or process, discussing medical social work primarily as a form of social casework. In this newest report on public health social work the various

functions and processes are discussed with equal emphasis and with the implication that the social worker has alternatives in building the total job. In other words, the worker is not just a caseworker but a social worker in the broadest sense.

I had the opportunity of participating in the preparation of this report and wish to speak of some of the values which seem to me to have emerged, also some of the further advances in thinking.

In connection with this report, I would like to call attention to our social work tendency to think predominantly in terms of professional processes, such as casework and consultation. We have seen casework as central in social work and have worked out basic social work concepts and skills through this medium. Recently a similar process has been taking place through consultation. This method of professional thinking has been useful but can become limiting and even confusing. It is my own feeling that it is now too narrow and may lead us off the track unless it is more broadly focused and related to the concept of social work as a whole.

Several experiences have influenced my present thinking. As a result of participating in a study of social work education,[3] I have learned to look at social work more objectively and to ask myself constantly why we are doing what we do. Through our efforts to revitalize the study of our practice under the Practice Committee of the American Association of Medical Social Workers, and with the newer insights gained from current research methods I have been further impressed with the need to watch our assumptions, and to go very carefully and simply in our thinking. Finally, in working recently at the Simmons College School of Social Work on a student research project, I experienced the practical application of such disciplined thinking.

In this student project, which had to do with casework and consultation in a group of selected cases, we tried to describe what was going on, without hidden assumptions or special lingo. Because we felt our concept of "consultation" was not sufficiently precise, we decided not to use it. It seems that, although the public health social worker is customarily called a "consultant," she appropriately gives many other services than consultation as a part of her total job. Therefore, to avoid confusion, we decided to start with straightforward questions about the worker's activity such as: When was she working with patients? When with other professional persons? What was the purpose of one or the other type of activity? Finding the answer to such apparently simple questions required very careful analysis of the material. We found much movement from one emphasis to another within one situation. We also observed that very often in the traditional type of case recording, when a worker records contacts with other health and welfare workers the record reads much the same, whether she is doing casework or consultation. In her own mind the worker knows which she is doing, but the reader of the record can not tell. In other words, we need to bring out much more clearly what approach the worker decided to emphasize, what factors influenced this decision, and whether a new approach was made during the ongoing situation.

Thus my present feeling is that, if we are to clarify our thinking, we must start farther back than process. In each situation we must first answer the question as to what we are trying to do, what needs are we trying to meet, before we can get at the ***how*** of the activity. That is, ***purpose*** and ***function*** must come before ***process.***

This fresh approach suggests that what we have here is a new kind of diagnostic thinking. As consultants we face wider alternatives in choice of focus, approach, and process, than we formerly did as caseworkers. I would like to discuss some tentative suggestions which it seems to me might be helpful at this stage of our work and in this connection. They are the result of some very hard thinking on my part in recent months. It is not easy to see one's way through these complex issues.

Emphasis on Program Development

First I went back to this initial question about ***what*** the social worker in public health is trying to do. What are the objectives? What is the content, the meat of the work? Here several ideas flowed together from different directions.

A point that has seemed important to me ever since I worked at the Children's Bureau some years ago, recurred to me; namely, that it is essential that we define the principles of well rounded health and medical care programs, as developed jointly by the Bureau and the States, since many of the peculiar characteristics of public health social work are due to the fact that it has emerged from broad, socially oriented health and medical care programs of this type. I feel that we cannot understand the one until we understand the other.

I also recalled something Gordon Hamilton had said at the meeting of the Council on Social Work Education at St. Louis in 1953. Contrasting the typical American and European approaches, she said that we in this country tend to stress the professional process while they tend to stress meeting needs through a program of services, not individualized. I have thought a great deal about this relation between program and process, and it became more meaningful to me when Frances Heald was presenting her work to my class at Simmons last spring. She brought out clearly how the public health social worker, even when working on an individual case, is always aware of all the other individuals with similar problems back of the one patient, and how she is constantly thinking of their need of services and of the gaps in community resources. Thus the public health social worker's focus and choice of activity is influenced by the fact that she is part of a broad program involving large numbers of people, where there is concern for the rights of all, for service to all, and for the preventive approach. This constant awareness gives the individual patient a different significance than he has in the hospital. There, the casework focus is primary, though there is also an awareness of the broader group of services surrounding it. In public health social work the consultant's objective is always services to individuals, but the emphasis is, appropriately, more on development of program, on building a program of services to people.

I am wondering if it may not help us as medical social consultants in public health if, each time we face a decision about an activity in a specific situation, we think first about what we are trying to do in long range program development, and in this light decide whether to focus on the case, or the policy, or the other worker. Having thought about purpose, we might then arrive at a choice of professional process.

Let me illustrate how such decisions seem to be made from two brief instances.

The first situation, used by Frances Heald in interpreting public health social work to my students, began with the referral of a premature infant discharged from a small local hospital, lacking a medical social worker. The public health social worker made a home visit and discussed, with the parents, their anxiety and confusion regarding the problem of payment for the baby's care. It so happened that this was the first such problem to arise in that locality since the passage of new State legislation regarding the care of premature infants. This case showed that policies and procedures under the new program were not understood by professional personnel in the hospital and in the community. Therefore the next step, carried through in collaboration with the District Health Officer and the Nursing Supervisor, was to arrange a conference at the local hospital, which was attended by all professional workers (the hospital administrator, local health department nurse, and others) concerned with this case or likely to be concerned with similar cases in the future. After deciding what should be done about the particular case in question, the discussion moved out into a consideration of the program as a whole and the meeting ended with a series of agreements regarding policy and procedure. At a third stage the local health department nurse, who would carry considerable responsibility for working with families in the future, sought a consultation interview with the public health social worker to clarify her thinking regarding some of the social implications of the new program and her approach to parents in helping them to understand it. Thus the public health social worker moved through three definite stages in which her focus and method (1) began as direct social casework, (2) enlarged to participation in policy formulation, and (3) ended as consultative service to another professional associate.

The second illustration, which I used recently in my own teaching, is from a casebook prepared for an institute for medical social teachers in 1948.[4] It begins with a consultation interview between a public health nurse and public health social worker regarding a child with an orthopedic handicap, who after long care in a hospital was suddenly discharged home to a family obviously unprepared to receive him. In helping the nurse to consider what might be done about the urgent problems of this child and family, the public health social worker became aware of the broader problem of hospital discharge policy so starkly illustrated in this situation. As a next step, therefore, she took this problem to the director of her program, asking that it be discussed in staff meeting, to which he agreed. At the meeting the various members of the public health team discussed the problem of local hospital discharge policies from their various angles and agreed what action each would take in exploring the problem and dealing with it. Thus in this situation the public health social worker (1) began with con-

sultative service to the local public health nurse, (2) moved next into an administrative conference with the program director, which led to (3) a multi-discipline meeting with good professional teamwork on a policy problem, eventuating in (4) action on a phase of a local community program by the public health social worker and her associates.

In these illustrations it should be noted how several processes are used successively by the public health social worker in the ongoing situation, which we recognize as having logical continuity. There is no break in the movement from one stage to the next. Consultation is appropriately used in relation to a number of other professional processes, all of which become greatly clarified when related to the social worker's changing and developing purposes.

Some Key Questions

In thinking further about these decisions that public health social workers must make in specific situations, I felt it would help if we could get at some of the key questions that have to be asked and answered. Too, frequently, they are answered only by implication and it would be better at this stage, if we really wish to define our functions, to answer them directly and consciously. Again I tried to get away from the old question of "casework versus consultation" and to use a fresh orientation. I worked on this with my Simmons class and we found that it helped to think of different programs—such as Crippled Children's Services, Vocational Rehabilitation, and Public Welfare—because sometimes the very nature of the program indicates the answer to one or another question.

The following are some of the possible questions, and they go in pairs:

1. How much of my work shall focus on case situations? and

How much shall be carried out through broader phases of the program, such as policies, community resources, education and research?

It should be noted that this question refers to any type of work with cases, not just casework.

2. Whatever the focus, shall I directly participate myself; that is, be active, take responsibility, in the situation? or

Shall I work only through other professional and lay persons?

The second alternative, not to participate directly but to work through others, represents "consultation" as we now think of it.

3. When shall I stress service by means of direct relationship with individuals served? and

When shall I stress service by means of relationship with other professional persons?

The final pair are questions which we are asking in the Practice Committee of the American Association of Medical Social Workers. This pair overlaps the first two mentioned above but is different in its implication. One can work on case situations without direct relation with the patient. One can work actively with other professional persons in a teamwork relationship or restrict oneself to a consultative relationship. The preposition ***with*** covers all types of participatory working relationships with professional associates. The preposition ***through*** seems to refer specifically to the inactive, consultative role.

I do not wish to say that these are the basic questions we shall finally arrive at, but I do want to suggest that this type of question-and-answer, simply phrased but actually penetrating in its implication, is needed if we are to understand what decisions public health social workers are making and why they are making them.

Implications for Recording

It will be recognized that there are important implications here for methods of recording. For further progress, it is evident that professional records must include more material showing the worker's purpose, decision, and methods, at various stages of a situation. Conscious recognition by the worker of these major elements in the moving situation is essential for ongoing professional study.

I wish to make clear that the kind of recording to which I am referring is not necessarily the daily record of the agency. It is a special type, very carefully and fully prepared, for purposes of (1) clarifying functions and processes and (2) providing material absolutely indispensable for teaching. It is highly selective. What is needed is quality rather than quantity. If each public health social worker prepared just one such record a year, we should have made an important beginning. The small nucleus of this type of recording which has so far been demonstrated is already of very great professional value in both practice and teaching.

Relation between Professional Activities

There remain some additional key questions of a slightly different type, which are increasingly con-

cerning me and which I believe should be included in this discussion. They take us beyond the decision in specific situations to the ***total job.***

We must ask ourselves: ***What is the nature of the relationship between the worker's various activities? What principles define this interrelationship?***

The recent report prepared under Children's Bureau auspices discusses the medical social work functions one by one, and implies that they are combined in one job, but does not attempt to say how. This takes us back to Gordon Hamilton's point, but we should note an important difference. She spoke of emphasis in Europe on ***program without individualization.*** In our public health social work we see the program emphasis as including social work, that is, the professional process is integrated with the program. I feel that criteria for relating the various activities will emerge as we clarify the purposes and decisions made by consultants in planning their work. One very important aspect, as we are all aware, is the relation of casework to other activities. In the hospital, casework is clearly central but in public health, particularly at the consultant level of functioning, the answer is not so simple. I am convinced that an essential step, which all social work must take, is to relate casework (with all it represents in basic knowledge, skills and philosophy) more clearly to the rest of social work. My own hypothesis is that this relation is basic to the nature of social work, which moves out from and back to the individual.

Thus my questions, based on observation in the hospital, are these:

1. When we are working with and through other professional personnel, is it necessary for them to see the individual service demonstrated in order to incorporate the social work viewpoint and use social work appropriately in administrative planning, clinical service, teaching, and research?

2. In carrying these various broader functions of an administrative, consultative and educational nature, we ourselves certainly must have a base of casework knowledge and skill. Is it enough if the worker has had it in the past? Does casework practice have to be strongly imbedded in our program, possibly at times even in our own current professional activity, in order to maintain the depth, validity, and effectiveness of other activities such as consultation?

We cannot give the answers yet, but I believe it is extremely important for the future of public health social work that these questions be asked and answered. It appears that the interdependence of casework and program-building, whether through consultation or whatever channel, will be found to be vital and must be better understood for real progress in our work.

I would like to end on a note given in the final paragraph of the Children's Bureau report, which says: "A developing profession in a developing field must experiment and study. Out of such experimentation and study will come growth in practice and in turn, better service to people." I want to add that the effort of the small group of medical social workers in public health has been truly a pioneer service, out of which is coming much that is of very great value for the entire field of medical social work, and even further, for the profession of social work as a whole.

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[1] American Association of Medical Social Workers: Report of study of medical social activities in public programs. Washington, D. C., 1951. (Mimeographed.)

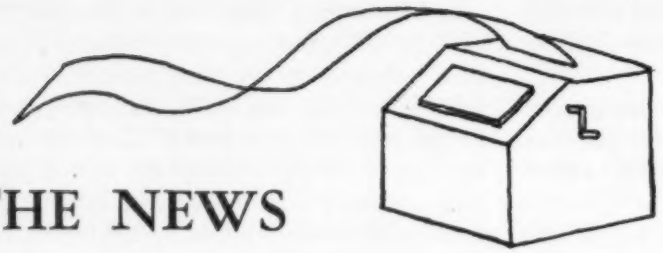
[2] Children's Bureau, Department of Health, Education, and Welfare: Medical social services for children in the maternal and child health and crippled children's programs. Washington, D. C., 1953. (20 cents.)

[3] Hollis, Ernest V., and Taylor, Alice L.: Social work education in the United States. Columbia University Press, New York, 1951.

[4] University of Illinois, Division of Services for Crippled Children: Medical social activities in public health and medical care programs. Prepared for the Institute for Medical Social Instructors. Chicago, 1948. pp. 66–67. (Mimeographed.)

"As well might one try to pick up a man's shadow and carry it away as to treat his physical ills by themselves without knowledge of the habits that so often help to make him sick and the character of which these habits are the fruit."

RICHARD C. CABOT, M. D.
in *Social Service and the Art of Healing,* 1917.



IN THE NEWS

From public and private sources IN THE NEWS gathers items for our readers' notebooks, speeches, or articles, on data or viewpoints in the fields of child health and welfare. The viewpoints are those of the person quoted, and not necessarily of the Children's Bureau. CHILDREN welcomes comments of readers on the value of "In the News."

More than half the country's 19 million working women are married, and 27 percent of all married women held jobs in 1953, according to a report by the Women's Bureau of the Labor Department. The report cites a "substantial" increase in wage rates for many kinds of women workers during the postwar period, but the median income rose only slightly, from $901 in 1945 to $1,045 in 1951. Median income for men rose from $1,800 in 1945 to about $3,000 in 1951 ● ● ● The statistically average mother in the United States bears her last child at the age of 27, according to 1940 U. S. Bureau of the Census figures.

Within the next decade, many teen-agers will no longer be able to benefit from baby-sitting jobs, the Institute of Life Insurance predicts. The increase in the teen-age population has been interpreted by the Institute to mean there will be fewer baby-sitting jobs to go around ● ● ● "Bronxville Families Agree" is the title of an eight-page pamphlet recently published in Bronxville, N. Y. The pamphlet, which deals with "out of school" behavior, is the result of efforts of a group of parents in Westchester County to agree on standards of social behavior to which they, as individual parents, will adhere in dealing with their youngsters. The booklet has been distributed through the school system to all parents with boys and girls enrolled in the 7th through the 12th grade classes of the Bronxville public schools.

Among the 1,100,000 men turning 18½ years of age annually, 30 percent are rejected for military service for all reasons, including physical, mental, psychiatric, neurological and moral, according to the U. S. Office of Selective Service ● ● ● As of July 1, 1952, Census Bureau estimates are that there were a total of 15,049,000 teen-agers in the United States (children between the ages of 13 and 19, inclusive). In the 20–24 age group, inclusive, there were 10,597,000 persons, according to the census estimates ● ● ● A "charter" containing a basic "statement of social principles" on family life is in first steps of preparation by the Family Service Association of America. A Committee on Public Issues of that Association will study those issues it believes to be "most urgent" concerns of family welfare ● ● ● Legislation recently enacted by the Philippine Government makes it compulsory for all children to remain in school until they have completed an elementary education ● ● ● Rates charged by general hospitals increased about 6 percent during 1953, the smallest annual increase in rates since 1949, the American Hospital Association reports. The Association based its figures on 2,563 questionnaires filled out by general hospitals. Rate figures covered all meals, including general or special diets, general nursing service and, in more than 60 percent of the larger hospitals, the cost of routine drugs ● ● ● Some misconceptions about health were revealed in a public opinion survey reported on at the annual meeting of the American School Health Association. The survey showed these misconceptions: A child's disfiguration may be caused by a mother's fright during pregnancy (believed by 1 in 4). Communicable disease can be inherited (believed by about half). Only one-third of those surveyed realized that the lower death rates of today are primarily due to the prevention of infant deaths, rather than to reduce adult deaths.

Closer cooperation on school health policies among the schools, community health officials, parents, and private physicians was urged in a report recently issued by the members of the School Health Committee of the American Academy of Pediatrics. Dr. John L. Reichert, chairman of the committee, said in an interview, reported in the New York Times, that mass physical checkups of school children were apt to create a sense of false security among parents. He said that an adequate physical examination takes longer than is possible with mass methods, and recommended a thorough examination, preferably in a doctor's office, with parents present for proper health protection and education. Dr. Reichert said intelligent health observation by school nurses and teachers should make one examination every 4 years adequate, although the yearly examination is still the ideal ● ● ● The general mortality rate dropped from 17.2 deaths per 1,000 population in 1900 to 9.6 in 1950, the National Office of Vital Statistics, U. S. Public Health Service, reports. Life expectancy at birth in 1900 was estimated at 47.3 years; in 1950 it was 68.4 years ● ● ● A look ahead at New York City's outlook for health services is contained in Now They Live, a publication of the Department of Health, City of New York. The pamphlet outlines some jobs that "should be given priority." Among them are developing more adequate and integrated rehabilitation services for the chronically ill and physically handicapped child; bringing more closely together both curative and preventive services for all children; placing greater emphasis on transforming into practice the present knowledge about the growth of a healthy body and particularly of a healthy personality.

New York is planning this year to launch a $250,000 program to provide

hearing aids for deaf children who cannot afford such devices. The State will cooperate with county governments in financing the program. State officials estimate that 1,500 children in the State are sufficiently hard of hearing to benefit from hearing aids, about half of them in families that cannot afford the equipment ● ● ● Since 1952, after the relaxation of controls on the sales of psittacine birds, the Children's Hospital of Philadelphia has noted a marked increase in the number of patients whose illness was clinically or epidemiologically consistent with psittacosis, the American Journal of Public Health reports.

Welfare

An estimated 285,000 children were receiving child welfare services from State and local public welfare agencies as of December 31, 1952. The Children's Bureau estimates that about 42 percent of these children were from homes broken by death, divorce, separation, or desertion of one or both parents; that an additional 18 percent of the children were born out of wedlock ● ● ●

Because of complex regulations and laws, a large scale study of the procedures and practices involved in international adoptions is needed, the American branch of the International Social Service has stated. One of the points which the agency thinks should be considered in such a study is the extent to which local child welfare and adoption agencies would be willing to cooperate on an international level.

Mental Health

Of 950,000 boys and girls registered in New York City's public schools, 11,500 are classified as retarded and are in special classes, according to Arthur Levitt, a member of the city's Board of Education. He estimated another 15,000 children of school-age in the city have varying degrees of mental retardation and do not attend public school ● ● ● More than 80 percent of American communities fail to provide adequate facilities for emotionally disturbed children who need special care, according to Joseph H. Reid, executive director of the Child Welfare League of America. Speaking before the annual conference of the New Jersey Welfare Council, Mr. Reid said that while 500,000 children with severe emotional disturbances were in need of some kind of treatment facilities, fewer than 1,500 were receiving adequate care in recognized residential treatment centers ● ● ● An education committee of the National Association for Retarded Children has established a clearinghouse to inform local parent groups of what other communities are doing in public school training, courses for parents, recreation programs, legislative action, and research on behalf of the retarded ● ● ● The Gifted Child in the Regular Classroom, a recent publication of Columbia University, reports that while the problems of a gifted child are basically the same as those of others the same age, gifted youngsters may need special attention from adults because of the reactions of others to their special abilities. The publication, by Miss Marian Scheifele, states the gifted child, as well as the retarded one, needs help to accept the inequality of his abilities, to understand his relationship to others, and to accept his responsibility to society.

Juvenile Delinquency

Behavior problems that might lead to antisocial acts in later life are recognizable in a child as early as 3 years of age, according to Dr. Ralph S. Banay, secretary of the Medical Correctional Association. In an address to the third annual Congress of Corrections in New York City, Dr. Banay said the danger period in which youthful delinquency is apt to be at its highest rate is from 13 to 15 years ● ● ● Special court attachés to deal with juveniles have been recommended by a special committee of the New York County Lawyers Association. The committee cited the importance of having a "competent and trained person . . . appointed in every case involving the custody of a child to report to the court those facts which would enable it to determine what would be to the best interests of the child in the case before it." The committee also recommended that judges be trained by the State before being assigned to social courts ● ● ● A report on the Children's Court of New York City has been prepared by Dr. Alfred J. Kahn, Professor of Social Work, Columbia University. Dr. Kahn, who studied the court under auspices of the Citizens Committee on Children of New York City, reported it needed thorough overhauling to reach its original goal. Among his recommendations were a less political method of appointing judges, better training for probation officers, attendants and clerks who deal with children, expansion of counseling, diagnostic and psychiatric services, and provision of more facilities, such as temporary shelter, foster homes and job-placement.

Child Labor

A critical report of conditions under which migrant children live was made last fall to the New York Joint Legislative Council on Migrant Labor by Sol Markoff, associate general secretary of the National Child Labor Committee. "Children are the worst sufferers," Mr. Markoff said. "Despite the earnest efforts of the State Labor Department, hundreds of under-age migrant children are unlawfully employed each year picking crops under a hot sun 10 to 12 hours a day in stooping, creeping, crawling, back-breaking jobs. The housing is frequently indescribable and many migrant families are crowded into filthy, makeshift shelters totally unfit to live in, and without any regard whatsoever for health, privacy or fire hazards."

Half a million more children were employed in 1950 than in 1940, the National Child Labor Committee reports. Largest increase was among children 14 and 15 years old. In 1940, 1 in 23 was working; in 1950, 1 in 11 was earning money. Most children in the labor force are part-time workers, still in school, the report shows.

Research

Nearly $20,000,000 was spent in 1952 for cancer research, and $4,500,000 for poliomyelitis research, according to Richard Weil, Jr., president of the National Association for Mental Health. Mr. Weil said less than $3,000,000 was spent during 1952 on the basic research dealing with the many mental illnesses now prevalent. He predicted that at least $10,000,000 would be needed in 1954 for research and training programs in the field of mental illness ● ● ● Expenditures for medical research have increased at a greater rate than the national income, according to Dr. Kenneth M. Endicott and Dr. Ernest M. Allen of the National Institutes of Health. They report money available for medical research has increased from $18,000,000 just before World War II to $181,000,000.

a person skilled in community organization helps county leaders to arrive at a plan of services for its children

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HELEN C. HUBBELL, M. S. W.

Chief, Division of Rural Child Welfare
Bureau of Children's Services
Pennsylvania Department of Welfare

Will you come with me for the weekend to Sullivan County? We will find ourselves in a county whose hillsides and meadows are knee deep in the lush green of June and whose mountains with their endlessness widen the heart and stretch the soul.

We have not come to see mountains nor to swim in Lake Eagles Mere, but to help the people in the county decide what they will do for their dependent and neglected children. Some of these children are tucked away in these mountains. Some are uncomfortably visible to the "resorters" at Eagles Mere as even that paradise has its "shanty-town." Still other children are scattered throughout the county.

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It is 7 o'clock, Friday evening. The air carries the sultry aftermath of a severe electrical storm, and the threat of more thunderstorms to come. A small group of perspiring people climb the stairs to the office of the County Board of Assistance where the executive has provided a large table, pads and pencils, and an electric fan.

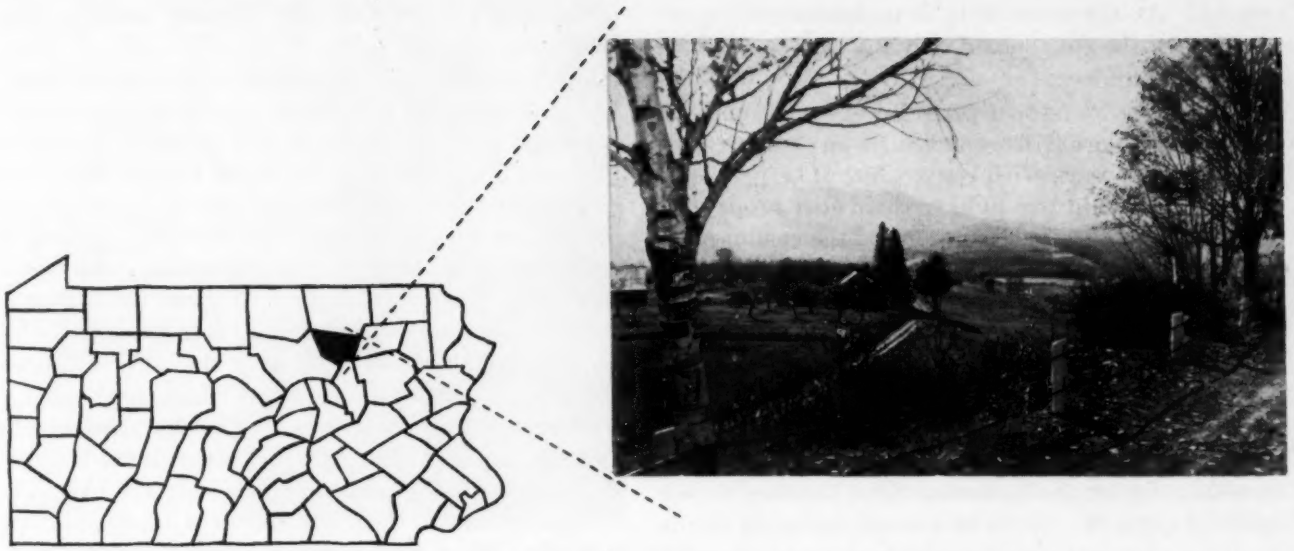
In joining the group around the table, we are introduced to 2 county commissioners, their solicitor, the chairman of the Children's Aid Association who is also county superintendent of schools, 4 child-welfare-minded women from 3 different communities, and my host for the weekend, a newcomer to the county within the last 6 or 7 years and active in civic affairs. The Board of Assistance director is in the group and the third county commissioner, the chairman of the Board, is expected to arrive about 9 o'clock.

Sullivan County has been taking care of its children in the traditional country way—in which "somebody" takes over in an emergency as best he can. The Children's Aid Association, a voluntary, loosely knit, group of men and women, has been working for more than 2 years to improve on these methods, to get something better as well as more dependable for the children who need help. Its members have given many hours of their time and traveled many miles. Tonight they have come once more to plead the cause of children living "down the road" and "back in the hills."

The association has considered various ways in which "something" might be done for these children. Volunteer service has been considered. Also, part-time paid service of a local person whose knowledge of "cases" and sense of social responsibility seemed sufficient qualifications. But it is the program of Rural Child Welfare Services of the State Department of Welfare that they have periodically presented to the commissioners.

The local communities in Sullivan County are too small to provide either the leadership or the funds for voluntary welfare agencies. And each community is so proud and self-sufficient that it finds cooperation with another, except on a county basis, difficult. It is clear that only the county acting as a unit is large enough to handle the problem. There are several ways in which the county might do this. But after considering them all, the Children's Aid Association is convinced that the child welfare services program is the best.

Under this plan the county would have a trained



Sullivan County's beautiful hills and valleys cannot conceal the children needing specialized care.

welfare worker whose salary would be paid from Federal funds and who would be under the field supervision of the State Rural Child Welfare Division. This would mean that she also had the use of psychological services and a centralized adoption service. In addition there would be a local advisory committee that would interpret the program to the public, and help to suggest foster homes.

The county commissioners are uneasy about this plan because they are afraid that if outsiders are involved, the cost to the county will grow larger and larger each year and soon be more than they can meet. But the commissioners have never definitely turned down the proposal. And as long as the possibility remains of getting what they know will meet their needs, the Children's Aid Association members cannot bring themselves to propose any less desirable solution.

And so time has dragged on and frustration has mounted. But tonight the Child Welfare Services Program is again to the fore. The county has recently been shocked by two serious neglect cases which, to the deep concern of the Children's Aid Association, had been disposed of without adequate planning or investigation.

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The atmosphere is electric, not only with storms but with the tension of people who have worked long and hard and who feel that the moment may have come which will decide the future of the county's neglected and dependent children. We see on the faces of some of those present a "now or never" expression and at the same time an eagerness to get on with the meeting, to see if by any chance "Harrisburg" can work miracles. All are ready to study the child welfare services plan which I have brought with me in tentative form.

To their surprise I present 2 plans—1, an extension of the CWS program from an adjoining county for 3 days a week; and the other, a CWS program of their own for 2 days a week. The latter was made possible very recently by the availability of an exceptionally well-qualified person living just over the county line but near enough to be "their worker." When the group learns that this worker is a farmer's wife and has relatives in Sullivan County, plan 1 almost goes out of the window, but the chairman very wisely asks me to review the advantages and disadvantages of both plans.

I emphasize the strengths there would be under plan 1: the tie-in with a well-established agency where there is an experienced director to supervise their worker and the program as a whole, and the availability of at least 3 days a week service. On the other hand, I recognize that plan 1 would be an extension of another county's service rather than their own. In addition, there might be problems in having one set of commissioners providing service to another; I state frankly that such a combination would be new to the Harrisburg office as well as to the county and therefore has many unknowns.

Plan 2 offers the county a program of its own with field supervision from the State office direct to the

county. At the same time it means more responsibility for the county and only 2 days a week service for the children.

The phrase "our own program" goes around the table almost like a Gilbert and Sullivan chorus. One of the women says with conviction, "The people in this county would like to have their ***own program.***" Heads nod in agreement and one of the commissioners says, "This is the program to have—our own and one that does not mix us up with another county." The lone dissenter is the county solicitor who reminds the group that they are taking away one day's service from the children. All of us recognize the truth of this and its implication for children but the "ownness" of the program seems the most important consideration at the moment. One member rather ruefully says, "It would be a small program but it would be a beginning and we just have to get started."

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While this discussion is going on, a summary of the child welfare worker's training and experience is passed around which includes this statement, "She would come to the job with interest and enthusiasm." This brings from one member the spontaneous comment, "Believe me, interest and enthusiasm are what we need! A lot of these people can be helped with just that." All of the group are impressed that the worker is not only a college graduate but has a master's degree in social work.

Comments continue . . . "I hope she knows that it will be a hard job." . . . "She will have to produce results" . . . "Yes; she will have to do some demonstration cases early to show the county people what this service is." Feeling sorry for the worker already, I remind the group that one worker 2-days-a-week cannot work miracles. There are murmured agreements.

By this time the worker is practically *in* the county and the two commissioners are thinking again of money. A "side-bar" conference between one of the commissioners and the county superintendent of schools results in an announcement by the commissioner that the worker's office can be in the office of the county superintendent, thereby absorbing in that budget stenographic service, office supplies, telephone, etc. With a triumphant stroke of the pencil the item for administrative costs from the county funds is crossed off the budget! This would have been the strategic moment for the chairman of the commissioners to arrive. His concern over these costs has been the stumbling block for 2 years. But he does not appear and another thunderstorm, crippling telephone service, prevents any contact with him.

The presiding officer has to leave for another meeting and informal discussion continues into which come the children by name and location, if not in person. The representatives from Eagles Mere talk about the neglected children of "shanty-town"; families where fathers have good jobs but are heavy drinkers and mothers are discouraged by the rejection of themselves and their children by the community. There are children "back in the hills" who do not come to school at all or if they do, with poor clothing and little or no lunch. "Just think what a worker could do for Carrie B. just by showing interest in her." "Look at the children in the L. family—I knew their grandparents and had their parents in school—none of them was able to bring up children decently. How can we expect anything of this generation!" "Preventive work will be the job, helping parents to make better homes."

Then the question comes to me: "How can a worker do this?" I tell the group of my conviction, born out of experience, that ***most parents want to be better parents*** and want to be liked by the people in the community. This is not questioned but rather approved in different ways especially by the women. I remind the group again that the worker is not a miracle-maker, that her interest and encouragement to discouraged parents are first steps in helping. Added to this are her skills in working with people. I point out the limitations in her responsibility, emphasizing that only ***the court*** can remove children from their own homes against the parents' objections.

I describe briefly the difference between a neighbor's approach to a neglect situation and that of the worker who represents not only an authorized agency but also the concern of the community of which the neighbors are a part. This brings comments from several people, emphasizing the importance of saving children from jails and penitentiaries "for their sakes and not just to save money." One member living close to an adjoining county which operates a service has, as a neighbor, one of its agency's foster mothers. She describes with feeling what a good foster home can give children. Climaxing this discussion is a commissioner's comment, "One good citizen is worth a dozen bad ones."

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Time is going on. The group is waiting for the third commissioner to appear, for the chairman to return, for the rain to stop, and above all for the meeting to take some direction. The women are

Laporte, with a population of 175, and said to be the smallest county seat in the U. S. A., is off to a new start with Sullivan County's child-care services.

clearly becoming "determined" to secure a decision from the commissioners, and one of them says emphatically and with some heat "If the commissioners cannot accept plan 2 which is inexpensive and represents a minimum of service then this county is hopeless!"

One commissioner states he is ready to sign plan 2. He looks to the other commissioner for agreement. The latter states that no final decision should be made without the chairman of the board. The group is silent. Will the decision again be delayed?

An empty feeling hovers over the group. It could become bitter. The silence is broken by a member saying, "This is the third time a representative from Harrisburg has met with us at our request. I feel that we have the obligation of courtesy, if nothing else, to make a decision." Again there is silence. The moment seems to have come for "outside leadership."

I offer to stay through the weekend and into Monday in order to see the three commissioners. I say, "The decision may be plan 1 or plan 2, or a refusal of both plans, but the people in the county as represented by those of us around the table are expecting a decision of some kind." The two commissioners react. They decide on a meeting Monday morning, the time to be determined later. The presiding officer who returns just at this crucial point, offers to take a copy of the plan to the chairman of the commissioners to "brief" him for Monday morning. I ask the group if there is enough agreement on plan 2 to discuss it with the child welfare worker while I am near enough to have a conference with her, making clear to her, of course, that no final decision will be made until Monday morning. The two commissioners agree to this and the others express approval.

By this time the group is breaking up and as we go to our cars we are almost oblivious of the pouring rain, so real is our feeling of hope and promise.

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And now we come to Sunday when the chairman of Friday night's meeting stops by to tell us that he has talked with the chairman of the commissioners, who will, he thinks, "go along with plan 2." He has called the Monday morning meeting for 9:30. This stop-by visit takes place during my conference with the prospective child welfare worker—Mrs. B.—who uses the opportunity to express her interest in the plan and her readiness to take the job if and when it is a reality.

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The fateful hour 9:30 a. m. Monday finally comes. We are welcomed by two friendly women in the commissioner's office. One of them is the commissioner's clerk who openly expresses her interest in what is going on and her opinion that "something for children is needed." The chairman of the Child Welfare Association arrives and the commissioners come in with their solicitor.

Plan 1 is not mentioned and the chairman gives his interpretation of plan 2. A few questions are raised and points clarified such as when the worker will come, what days she will be in the county, and whether long distance telephone calls save time and money.

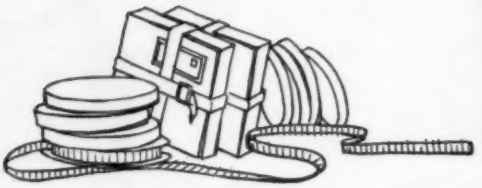
Suddenly, while I am still expecting more questions, the chairman of the commissioners instructs the clerk to write to Mrs. B. for an appointment for their next meeting date. Now it is practically all over and we shake hands all around.

I do not express all the enthusiasm I feel for I realize that this matter-of-fact approach to "high moments" is the pattern of the county and has in it a mixture of a quiet sense of achievement and fear of the unknown.

I leave the group expressing my deep satisfaction in our joint accomplishment and the need for us to stay close together as the program goes along.

As I drive down into the valley and the mountains seem to encompass me, their height seems no greater nor as great as the experience of seeing people use their vision and stretch their souls to encompass the needs of their fellow men.

FILMS ON CHILD LIFE



This department of CHILDREN, which will appear in alternate issues, includes films that have been reviewed by staff members of the Children's Bureau. Listing a title does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

BROKEN APPOINTMENT. 22 minutes, sound, black and white, purchase or rent.

A public health nurse learns, in dealing with a broken appointment in a prenatal clinic, how important her attitudes toward her clinic patients are, and how much her own personality influences her relationships with them.

Audience: Public health nurses especially, but also any student nurses.

Produced by: Affiliated Film Producers for Pennsylvania Department of Welfare under the sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

CEREBRAL PALSY—METHODS OF AMBULATION. 17 minutes, sound, color, rent.

The apparatus used to help children develop ability to walk, and every stage in the preparation of the cerebral palsied child for walking are shown.

Audience: Professional workers; lay groups working to establish programs for children. Not for general showing.

Produced by: National Society for Crippled Children and Adults, Inc., 11 South LaSalle St., Chicago 3, Ill.

Distributed by: Same.

DRUG ADDICTION. 22 minutes, sound, black and white, purchase or rent.

Stressing the "experimenting" idea of teen-agers who get "hooked" because of being "dared" or willingness to "try anything once," the film gives an unmelodramatic picture of how the drug habit is started and what it leads to.

Audience: Teen-agers, parents, professional workers.

Produced by: Encyclopedia Britannica Films, in cooperation with the Juvenile Protective Association and the Wieboldt Foundation, Chicago.

Distributed by: Encyclopaedia Britannica Films, P. O. Box 358, Wilmette, Ill.

FIRST DAYS IN THE LIFE OF A NEW GUINEA BABY. 20 minutes, sound, black and white (Character Formation in Different Culture Series), purchase or rent.

Details, from 3 or 4 minutes past birth, in the care a newborn among the Iatmul suggest the possible influences on personality development of different methods of handling babies. Commentary by Margaret Mead.

Audience: Students of child development; parents' study groups.

Produced by: Gregory Bateson and Margaret Mead.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

FIRST LESSONS. 21 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent.

Illustrating the techniques developed by Dr. Ralph Ojemann for the study of human relations, the film shows how an alert and understanding teacher restored a normal and happy balance to a second grade classroom disrupted by a new boy whose emotional difficulties led him to bully other children.

Audience: Parents, teachers, students in various professions.

Produced by: Knickerbocker Productions for Iowa Mental Health Authority, under sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Suite 308, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

GOOD SPEECH FOR GARY. 22 minutes, sound, black and white, purchase.

A second-grade boy who suffers from a speech defect improves his ability to communicate through modern remedial speech teaching. The detailed account of this process underlines the importance to such a handicapped child of having a teacher with a knowledge of a child's nature and needs if she is to help him overcome the effects of such a handicap on his personality.

Audience: Parents, teachers, student teachers, nurses, social workers.

Produced by: The Cinema Department of the University of Southern California.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N. Y.

HOW TO SAY NO. 10 minutes, sound, black and white, or color, purchase.

Five high-school students play out how to keep friends while saying "No" when asked to join in undesirable activities. The presentation moves from situations where it is relatively easy to say "no" to some of the tough issues that face boys and girls.

Audience: High school students; parents, teachers, public health nurses, who might wish to use the ideas as lead-off points in discussions with boys and girls.

Produced by: Coronet Films.

Distributed by: Coronet Films, 65 East South Water Street, Chicago 1, Ill.

KARBA'S FIRST YEARS. 20 minutes, sound, black and white (Character Formation in Different Culture Series), purchase or rent.

Scenes in the life of a Balinese child beginning with his seven-month birthday ceremonial. The child is suckled, taught to walk and dance, tickled, and teased.

Audience: Professional persons concerned with child rearing practices; students of child development.

Produced by: Gregory Bateson and Margaret Mead.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

MENTAL HEALTH. 12 minutes, sound, black and white, purchase or rent.

Situations of significance to high-school and junior-college students are portrayed to illustrate ways of meeting the dangers of bottling up emotions, setting expectations of self too high, failing to make friends through denial of what one has to offer, and worrying about problems rather than facing them.

Audience: Young people, adult lay groups, churches, clubs, P.T.A.

Produced by: Encyclopaedia Britannica Films.

Distributed by: Encyclopaedia Britannica Films, P. O. Box 358, Wilmette, Ill.

MY CHILD IS BLIND. 20 minutes, sound, black and white, purchase or loan.

The parents of a blind child, facing the fact that he will never see, and that he needs help beyond what can be given at home, place him in a nursery school for the blind. The daily routine there shows how much is done to make the children independent, happy in learning, and able to enter into some activities with normal children.

Audience: Lay or professional.

Produced by: Victor Solow of Unity Films for the U. S. Army in cooperation with the Lighthouse Nursery School.

Distributed by: United World Films, Government Films Department, 1445 Park Avenue, New York 29, N. Y., for sale; Association Films, Inc., Broad at Elm, Ridgefield, N. J., for loan under the title I SEE THE WIND.

PRENATAL CARE. 23 minutes, sound, black and white (Education for Childbirth Series), purchase or rent.

The medical care given patients during the prenatal period, with instructions for exercises in preparation for labor and delivery, and the use of breathing exercises during labor.

Audience: Groups of expectant parents when an informed nurse or other professional worker is present to interpret.

Produced by: Medical Films, Inc.

Distributed by: Medical Films, Inc., 116 Natoma Street, San Francisco 5, Calif.

RIGHT OR WRONG. 10 minutes, sound, black and white or color, purchase.

A chain of incidents involving important moral decisions by each boy is set off when a group of teen-agers break windows in a warehouse. Questions are posed whether the decisions of each child involved are right or wrong.

Audience: Adolescents, parent groups, students of teaching or social work.

Produced by: Coronet Films.

Distributed by: Coronet Films, 65 East South Water St., Chicago 1, Ill.

ROOTS OF HAPPINESS. 25 minutes, sound, black and white (Emotions of Everyday Living Series), purchase or rent. (Available in English or Spanish.)

The everyday homelife of a Puerto Rican family and how the feelings of the parents affect the emotional life of their children.

Audience: Groups interested in family life or mental health.

Produced by: Sun Dial Films for Puerto Rico Mental Health Authority, under the sponsorship of Mental Health Film Board.

Distributed by: International Film Bureau, Room 308–316, 57 East Jackson Boulevard, Chicago 4, Ill., for sale; National Association for Mental Health, Film Library, 13 East 37th Street, New York 16, N. Y., for rent.

SHYNESS. 22 minutes, sound, black and white, purchase or rent.

From one classroom, the teacher finds that of three quiet, friendless children, one's aloofness is merely part of his independent personality; one has fears and insecurities that have made him emotionally sick; one is typically shy and without help from understanding and observant persons could become a lonely, frustrated adult.

Audience: Teachers, student teachers, and parent groups.

Produced by: National Film Board of Canada.

Distributed by: McGraw-Hill Book Co., Text-Film Dept., 330 West 42d St., New York 36, N. Y., for sale; National Film Board of Canada, 1270 Avenue of the Americas, New York 20, N. Y., for rent.

THE TOYMAKER. 15 minutes, sound, color, purchase or rent.

Through two of his puppet creations, a toymaker shows how surface differences can lead to conflict and how peace and harmony can develop from mutual understanding.

Audience: Children and adults; leaders of discussions on human relations.

Produced by: Stevens-Rose-Wallace Puppet Films.

Distributed by: Athena Films, 165 West 46th Street, New York 19, N. Y.

V FOR VOLUNTEERS. 20 minutes, sound, black and white, purchase or rent.

When a young woman's interest in volunteer work is aroused, she learns the satisfaction that can be gained by participation in community service.

Audience: Any organization or group trying to awaken interest and increase the number of volunteer workers.

Produced by: National Film Board of Canada.

Distributed by: Association Films, Inc., Broad at Elm, Ridgefield, N. J.

WHEN SHOULD GROWNUPS STOP FIGHTS? (Preschool Incidents, No. 3), 15 minutes, sound, black and white, (Studies of Normal Personality Development), purchase or rent.

Rather serious difficulties arise following four incidents of nursery school play. These conflicts are not resolved, leaving it to the audience to discuss whether or not the teacher should have intervened.

Audience: Students, teachers, parents.

Produced by: Department of Child Study, Vassar College.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

a medical social worker is proving it in Panama, but there are many other places where . . .

VOLUNTEERS CAN HELP

BETTY HUTCHINSON, M. S. W.

Medical Social Work Consultant, Republic of Panama under the Technical Assistance Program, Foreign Operations Administration

MY FIRST IMPRESSION as I walked through the wards of Children's Hospital of Santo Tomas Hospital was that of a sea of little sad faces and big brown eyes that followed every move I made. Wailing children would stop their crying long enough to ask when their mothers were coming to take them home. Older, ambulatory children hung around the doorways or followed at a distance, full of curiosity. The need of others for individual attention and affection was pathetically demonstrated in their reaching out to grab a hand, cling to my skirts, or follow as close as they could, as I walked from ward to ward. Many of the children hung around the halls and the nurse's desk paying little attention to frequent requests to return to their beds. Little groups stood near the elevator doors watching people come and go, fascinated by the operation of the self-running elevator.

My assignment under the Technical Cooperation Program was to develop medical social services at Santo Tomas Hospital, the large General Hospital serving the Republic of Panama. Children's Hospital, a separate building but administratively a part of Santo Tomas Hospital, was selected as the starting point.

A preliminary survey revealed an average of 100 to 150 children of both sexes up to 14 years of age. Most of the children come from Panama City and its suburbs, but many also come from the Interior, especially those needing orthopedic treatment or having serious and unusual illnesses for which no local medical treatment is available. Some children, particularly those receiving orthopedic treatment, remain in the hospital as much as a year. Transportation to many of the villages of the Interior is difficult. In order not to lose the patient and interfere with the medical treatment, these village children are kept in the hospital between operations rather than allowed to go home for intervals. Such children seldom have any visitors or family members to give them individual attention and affection. They are lonely and bored and apt to be a problem to the overburdened nurses who cannot give them the individual attention they need.

A small volunteer program is now operating at Children's Hospital. This program is the result of spontaneous efforts for the recreational and emotional needs of the children on the part of students and social workers who have worked with me in a pioneering venture to develop a social service department.

Obviously, many of these children and their fami-

A former kindergarten teacher has volunteered to help the small patients with their cut-out work.

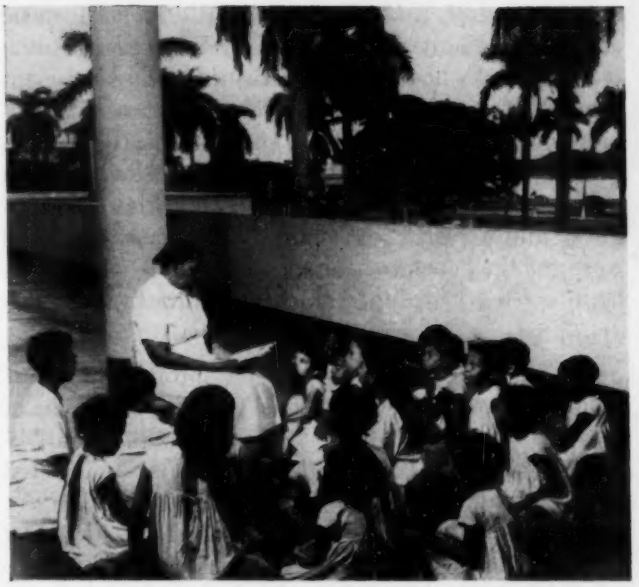
lies were in need of social casework. But some other needs were even more urgent. Children hospitalized for over a year were missing an opportunity for schooling. There was quarreling among older children. The nurses complained that the children were always underfoot. The few fortunate children who had relatives who could bring them toys to relieve their boredom had a hard time hanging on to them.

Our project got its start in March 1952 when a graduate social worker, employed as a teacher, came to work in the department during her 6-weeks vacation. She had come for some supervised social work experience.

As a teacher and so familiar with the Magisterio Panameno Unido, a professional teacher's association, she suggested approaching this association with a request for cooperation in providing volunteers to teach the school-age children. We drafted a letter to the association, explaining the children's needs and requesting a visit from a representative should the group be interested in this project. In addition, this teacher called on the president of the association to explain the project in further detail.

Weeks went by and we heard nothing. Shortly after our teacher left the department to return to her teaching, two women representatives of the association came to offer their services as volunteer teachers. Both were retired teachers, living on pensions, who had a great interest in children and a real desire to serve them. These teachers were given a brief orientation in the form of introductions to hospital personnel and an explanation of the medical requirements of the children and the ward routines. With the chief nurse, a schedule of classes with the children was worked out for them for the afternoons from 2 to 4, the most convenient time from the standpoint of medical and nursing procedures to bring the children together.

Each teacher now comes two afternoons a week, and both have been extremely faithful in keeping to their schedules. Every Monday, Wednesday, Thursday, and Friday afternoon, school is held on the porch-terrace outside one of the wards. This porch is equipped with small tables and chairs which serve the dual purpose of dining room and schoolroom. The space is open and shady and in an ideal position to catch the cool breezes of the blue Pacific. On these afternoons the wards are half empty and most of the children, able to get out of bed, can be found on the porch surrounding the teacher, working on arithmetic problems, or learning songs and poems. The teachers give individual work to the bed patients.



A bit of the Pacific shows in the background of the terrace where a retired teacher reads a story.

School calls for school supplies, and the teachers themselves could not furnish these from their meager pensions. The president of the Lions Club, an enthusiastic friend of Children's Hospital, responded willingly to my appeal for school supplies. In his characteristically efficient way he appeared a few days later loaded down with notebooks, pencils, chalk, four blackboards and other minimum essentials. The blackboards are now hanging on the walls of the porch-terrace on each floor available to the teachers.

This teaching activity is by no means the equivalent of regular schooling but it helps somewhat to keep up the habit of learning and keeps the children occupied and stimulated. Even the little ones, who do not know what it is all about, tag along and scribble away contentedly. All the children know the days the "maestras" come and inquire about them on the rare occasions when they do not show up. The children's response to the teachers has been touching and the main reward for the volunteer's efforts.

The need for school teaching having been met in part, the next problem was to find volunteers for recreational activities and just plain "mothering." I was extremely fortunate in becoming acquainted with the assistant director of the United Services Organization—Jewish Welfare Board-Armed Services Center—in the Canal Zone. For several years, previous to her present position, she had been a paid director of volunteer services in Beth Israel Hospital in Boston, Mass. She was very gracious in responding

to my request that she visit Children's Hospital and give me some advice as to what activities volunteers could do, how to recruit them, and how to orient them to their duties. The help she gave was invaluable. As a result of her suggestions, the following volunteer information sheet was worked out and mimeographed in Spanish and English to use as a guide and a recruiting device. The English copies were for the benefit of Canal Zone people who might be interested in volunteering at Children's Hospital.

"Dear Volunteer:

"In offering your help you are joining the great number of people who derive genuine satisfaction through some kind of service to mankind. Contributing to the social needs of people calls for devoted service, genuine interest, and responsibility. It requires a sacrifice of time and energy for which you receive little thanks or recognition, no publicity or special benefits other than the satisfaction of contributing to the happiness of others.

"If you are really interested in this kind of service and can give regular service at regular hours, we need you. Below are listed the various activities from which you can choose something that interests you. Some of these activities require that you have training and orientation so that what you do will be well done and of genuine help. The children hospitalized at Children's Hospital need your help and interest.

"Office Work:

Morning hours to do the following activities:
Type index cards
Type case histories
Be in the office to answer the phone
Must speak some Spanish and have a half day of orientation and instruction.

"Recreational and Other Activities With the Children on the Wards:

Afternoon hours 2 to 4, and possibly some late morning hours, for the following activities:

1. Interest the children in games and help in play activities.
2. Provide paper and crayolas and help the children, particularly bed patients, with a drawing period.
3. Provide the children with scissors, magazines, and paste and help them make scrap books.
4. Provide a record player and records for a music period.
5. Read or tell stories.
6. Secure craft materials and teach the children simple crafts.

Numbers 1, 5, and 6, require an adequate command of Spanish. Other activities can be done without knowing Spanish, with much demonstration and imagination. Require one day of training and all work to be done under supervision of the social service department.

"Individual Family Service

Preferably morning hours, but in some cases could be done during the afternoon:

1. Deliver food, clothing, etc., to families.
2. Provide transportation for patients to the hospital or home from the hospital or to other health units.
3. Provide transportation to social workers who have to make home visits in out-of-the-way places in Panama City not reached by ordinary means.
4. Deliver messages to families.

These activities are on a call basis but many could be scheduled to use a volunteer once or twice a week. An orientation period is required of all volunteers who will have contacts with families. All individual family service will be done under the direction of the social worker responsible for the case. Spanish is required except for simple transportation activities.

"Financial Assistance

This does not require that the volunteer maintain any definite hours. It requires making money available to meet the special needs of patients and their families such as food, milk for babies, clothing, transportation, special medications and equipment. Financial assistance to be provided case by case at the request of the social worker or by a regular allowance to the hospital social service fund. The actual food and clothing can be provided in lieu of money when feasible. This activity does not require any orientation unless it becomes involved in actual work in the hospital or in contacts with patients.

"Miscellaneous Activities

1. Helping feed the children at meal time, especially the small bed patients and babies on formula. This activity can be done at break-

fast, lunch, or supper. Requires one day of orientation; does not require Spanish.

2. Guide and messenger service in the out-patient department during clinic hours, 7:30 to 12:30. Requires good knowledge of Spanish, ability to withstand noise and confusion. Will require 2 days of training and orientation.
3. Securing pictures, storybooks, and play equipment for the wards. No orientation needed; no knowledge of Spanish.
4. Taking older children, who have been hospitalized a long time and ambulatory, on day excursions or to your individual homes to spend the day. This is to be done with the consent of the medical staff and the desire of the child and parents. Requires knowledge of Spanish or having someone available who can speak Spanish. One day of orientation and instruction."

These sheets were presented to one woman's organization with a request that it take on volunteer activities as a project. The group was interested, but since it was made up primarily of young married women with small children, the members were fearful of exposing their own children to illness through their contacts with the sick children in the hospital. They turned down the volunteer project, but they offered to help secure supplies and equipment for other volunteers.

No mass recruiting program has been done. Four women have volunteered their time. Each was found individually by use of the volunteer sheet and individual interview. One, a kindergarten teacher, comes every Tuesday afternoon and guides the children in a drawing and paper crafts period. Another schoolteacher comes every Saturday afternoon for drawing activities, to teach songs, and to make the rounds of all the wards talking with the children in an affectionate, motherly way. On her own initiative she is planning a small exhibit of the children's work. A third volunteer brings a record player and plays records for the children on Tuesday mornings. The fourth, a young girl, comes at irregular intervals, as her educational schedule permits, to distribute toys and read stories.

To the children, all these women are "maestras" and when any new person appears in the wards they eagerly inquire if it is a new maestra coming to teach them. An organization of young men, "Los Don Juanes," provides movies for the children every Friday night. This is a mixed blessing: wonderful for the children, but disrupting to the personnel who also want to see the movies.

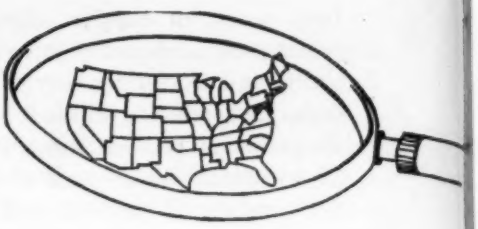
Without the cooperation of the nursing and medical staff this small volunteer program could not have functioned so smoothly. Many more volunteers could be used to good advantage. This program has developed gradually, picking up people as they become interested. As indicated in the registration book in which all the volunteers register their hours of work, so far they have given 120 hours of volunteer service.

The greatest satisfaction to the volunteers has been the response of the children and the appreciation of the nurses who find there are fewer problems when children are kept busy and interested.

"We have reached the age as a Nation when entire towns, cities, and regions have gone to seed economically and physically, and when imaginative, long range physical planning and social engineering are required. Organized health and welfare groups should be a dynamic and integral part of such movements, but they should not and cannot handle them alone. Over 30 years ago Patrick Geddes, the social scientist, coined the phrase 'geotechnics,' which was his term for 'the science of making the earth more habitable.' It is something as broad and comprehensive as that which must concern us in health and welfare planning."

LEONARD W. MAYO,
Community Planning for Health and Welfare, National Conference of Social Work, 1952.

PROGRAM DEVELOPMENTS



From their vantage points in regional offices over the Nation, the Children's Bureau staff reports periodically developments in health and welfare programs for children. The items which follow come from recent reports of Child Welfare Representatives.

Administration

New legislation in **Wisconsin** creates a department of public welfare in every county to administer all public assistance programs. If requested by the county board of supervisors, this department may administer child welfare services. A children's code commission, created effective July 1, is to make recommendations to the 1955 session of the legislature in regard to various aspects of the child welfare program.

A Division of Child Welfare and Guardianship has been created in the expanded **Minnesota** Department of Public Welfare. This division will include services for retarded children.

Plans have been completed in **Massachusetts** for the transfer of responsibility for the care of approximately 1,100 children now under the supervision of the city of Boston to the Division of Child Guardianship of the State Department of Public Welfare.

In **Illinois** a new Youth Commission has been established with the appointment of a three-member administrative board. Parole services, youth and community services, and the State training school for boys and girls were transferred from the Department of Public Welfare to the Youth Comission January 1.

Missouri's Division of Child Welfare has recently revised its Child Welfare Manual to include a section on Services to Children in Their Own Homes, which includes a definition and discussion of protective services.

Iowa has established a new position to deal with staff development in child welfare. It is expected that this will further improve children's services in public welfare programs, as well as intensify the staff development program.

Licensing and Standard Setting

Licensing of child caring agencies and institutions has received concentrated attention in **Ohio** because of the publication of proposed rules and regulations. After more than 25 years of operation the State Department of Public Welfare moved, for the first time, to issue binding requirements. Ohio will go ahead with the licensing of day-care facilities in accordance with legislation which became effective July 1.

The **Alaska** Territorial Department of Public Welfare has been studying and licensing children's institutions and expects to complete the task by the end of the year. The department will then concentrate on the study and licensing of 34 day-care facilities. Standards of day care are in the process of completion. Plans for a second child-welfare conference are in the preliminary stages.

Adoption

The **Montana** Department of Public Welfare invited representatives of the Catholic Charities, the Lutheran Welfare Service, the Montana Children's Home (which has no institution but operates a foster family care program), and the Florence Crittenton Home to participate in a workshop on adoptions held in Montana, August 31 to September 4, 1953. Discussions pointed up the need for flexibility and high standards as well as for cooperative procedures.

In **Pennsylvania,** with the passage of the Adoption Law, an advisory committee on adoption standards was appointed. The committee has developed minimum standards for agencies or institutions in relation to adoption practices under the new legislation.

Juvenile Delinquency

Rhode Island's juvenile court has cooperated with the University of Rhode Island in developing a course of instruction for police officers, attendance officers, and probation counselors dealing with juveniles. The court is also initiating a community planning program in South Providence in cooperation with religious, educational, social, and other agencies and organizations.

New York City's Youth Board loaned a research technician to Puerto Rico's Child Welfare Bureau to study problems of collecting basic data on the volume and incidence of delinquency. The report recommends the establishment of a central registry for juvenile delinquency. The Governor's Advisory Committee on Juvenile Delinquency is now collecting information on programs of control and prevention.

Three groups are concentrating on the study of juvenile delinquency in the **District of Columbia.** They are the District Commissioners, who have proposed a plan for a District-wide Council on Delinquency with smaller neighborhood or precinct councils to work on the problems; the District's Council on Law Enforcement, created by Congress to study all crime in the District; and a subcommittee of the Senate Judiciary Committee, under the chairmanship of Senator Hendrickson, which is studying Nation-wide juvenile delinquency.

The **Greater Boston** Council for Youth recently approved a 3-year experimental program in an area of high teen-age group concentration which will attempt to (1) identify and reach these groups and individuals who show antisocial and delinquent behavior; (2) strengthen and enlarge basic community services to those with serious social problems; and (3) intensify and coordinate efforts of all community groups

seeking to raise the general standard of living in the area. A tentative budget for this project is estimated at $210,000 for the 3-year period.

The National Probation and Parole Association has been making a Statewide study of needs of delinquent youth in **New Mexico.**

North Dakota's training school received an appropriation to purchase psychiatric service from the recently established State mental health unit in Bismarck.

In **Arkansas** and **Oklahoma** the child welfare divisions of the State Departments of Public Welfare are providing service to one or more of the training schools in their States. Both divisions are offering foster care, when needed, to boys released from training schools and supervision of children returned to their own homes. Public assistance workers in Arkansas are making certain social studies of children admitted to the training schools.

Homemaker Service

Rockville, **Maryland,** has had a demonstration of homemaker service administered by a public health lay council. A study of this program has recommended that this service be placed under a more formally organized agency, and the Board of the Social Service League, a voluntary agency, has agreed to take over the service.

Mississippi is initiating a homemaker service for the care of children in their own homes.

A Division of Chronic Illness Control has been created in the **New Jersey** State Department of Health. In a budget of over $20,000 for the first year, $6,000 are earmarked for a homemaker service and will be used to set up about 10 training centers. These will probably be under the Extension Service of Rutgers University. The New Jersey State Department of Health has made a full-time medical social worker available to the Division with the understanding that the greater part of her time will be spent on homemaker service.

A homemaker service was established on October 1 in St. Petersburg, **Florida,** under the auspices of The Juvenile Welfare Board of Pinelass County. For the present this service is available only for homes where child welfare is involved. With more than fifty applications to choose from, the Board has found eight unusually well qualified women whom they can call on for homemaker service as the need arises. Two of these are social workers who were offered and refused better paying positions in order to do this type of work.

Unmarried Mothers

Funds for new buildings are being solicited by the Florence Crittenton Homes Association in Terre Haute, **Indiana,** and by the Salvation Army in Louisville, **Kentucky.** The Salvation Army in St. Louis, **Missouri,** reports that it is now caring for mothers on a non-segregated basis and that the plan is working satisfactorily.

The **Louisiana** State Department of Public Welfare is revising its standards on maternity home care.

When the **Indiana** Board of Health terminated special medical care for unmarried mothers, the Children's Division of the Department of Public Welfare added this care to its program for unmarried mothers and their babies.

Emotionally Disturbed Children

In **Kansas** plans are progressing for the establishment of a State-operated treatment center for emotionally disturbed children. In making these plans the Director of Institutions has used the advisory services of a committee from the Kansas Council on Children and Youth. A site on the grounds of the Topeka State Hospital has been selected. Final decision on the exact nature of the program has not yet been made.

The **New Hampshire** State Legislature, in its 1953 session, authorized funds for the construction of a residential treatment unit for about 30 children. This new unit will include the present child guidance outpatient clinics. It will be located on the grounds of the State Hospital in Concord, but will be well removed physically from the other hospital buildings.

Handicapped Children

This year, for the first time, the annual conference of the **Illinois** Commission on Handicapped Children included special sessions for caseworkers. At this tenth annual conference, meetings were held for citizens and educators and also for social workers on the subject of The Handicapped Child in the Main Stream.

Indian Children

A child welfare worker has been assigned to Glacier County, **Montana,** to cooperate with the social worker at the Blackfeet Agency at Browning, and child welfare workers have been placed in Bannock and in Bingham Counties, **Idaho,** where they will be available for work with the Indians on the Fort Hall Reservation.

INTERNATIONAL

Widespread interest in the adoption of children from foreign countries continues. New legislation authorizing the bringing in of children for adoption was enacted by Congress in 1953 through two laws authorizing: (1) 500 nonquota visas for children adopted or to be adopted by United States military or civilian personnel employed overseas (Public Law 162), and (2) 4,000 nonquota visas for children to be adopted by United States citizens (Public Law 203).

Two organizations concerned with international adoptions have been particularly active in recent months. One, the International Adoption Association, has been contacting agencies abroad. The other, International Social Service, held a conference in the fall of 1953 to discuss the need for a centralized agency to handle international adoption matters. It was recommended that efforts be made to establish such a service.

INVITATION TO READERS

The number of copies of each issue of CHILDREN—successor to The Child—which can be distributed free of charge is extremely limited. Much as we regret, it is impossible to furnish copies to all persons who had been receiving personal copies of The Child. However, within limitations, we shall make every effort to furnish copies of CHILDREN to:

State departments of health, welfare and education; State crippled children's services located in other departments.
Institutions and specialized courts dealing with delinquent children.
Professional schools accredited to train child health and welfare personnel.
National offices of professional societies and associations.
Foreign and international agencies dealing with children.
University and major public libraries.
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We request that recipients of copies furnished without charge circulate them among their staffs and that issues be placed in libraries or a central office where they will be available to others.

If your position in any of the above groups entitles you to be placed on the free mailing list, please complete the following application form and send it, as soon as possible, to the Children's Bureau. Your application will receive every consideration.

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SOME PUBLICATIONS OF THE CHILDREN'S BUREAU FOR PROFESSIONAL WORKERS

MEDICAL SOCIAL SERVICES FOR CHILDREN. Pub. 343. 1953. 49 pp. 20 cents.

Medical social work evaluates itself in terms of the functions carried by these workers in the maternal and child health and crippled children's services under the Social Security Act. Much of the thinking that went into this pamphlet was generated at a meeting of State and local medical social consultants, and medical social representatives of the professional organization, education, practice in hospitals, and the Public Health Service. Public health administrators, educators, and other professional personnel involved in the care of mothers and children will find this a useful interpretation.

RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN, a listing. 1952. 78 pp. 20 cents.

Information is given on 36 centers whose primary function is the diagnosis or treatment of children with emotional and personality problems. Services are as of the spring of 1952. No evaluation of programs is attempted.

CHILDREN LIVING IN THEIR OWN HOMES. Pub. 339. 1953. 52 pp. 20 cents.

The purpose of this publication is to set forth the range of social services that should be available in each community through child welfare programs to help parents in their task of child rearing and thus to safeguard and strengthen family life. Children who may be in need of social services are identified, and the variety of social services required is described.

ALLIES FOR CHILDREN, Child Welfare Reports No. 5. 1953. 22 pp. Individual copies available from the Children's Bureau.

Drawing on plans and budgets of State child welfare services, this report shows how public and voluntary agencies work together in community planning for child welfare.

A SELECTED BIBLIOGRAPHY ON JUVENILE DELINQUENCY. 1953. 41 pp. Individual copies available from the Children's Bureau.

With the need to find ways of combatting juvenile delinquency assuming new urgency, this bibliography has been prepared as a guide to professional workers to recent thinking on matters of cause, prevention, and treatment.

CHILDREN'S BUREAU STATISTICAL SERIES: Main Causes of Infant, Childhood, and Maternal Mortality, 1939–1949. No. 15. 1953. 14 pp.

Personnel in Public Child Welfare Programs. 1953. (Data cover 1952.) 18 pp.

Childhood Mortality from Accidents. 1953. (Data cover 1949.) 6 pp.

Individual copies available from the Children's Bureau.

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